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MEXICAN AMERICAN PARENTS' BELIEFS ABOUT THEIR ADOLESCENT'S MENTAL HEALTH AND PARENTAL USE OF ALTERNATIVE INTERVENTIONS

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MEXICAN AMERICAN PARENTS' BELIEFS ABOUT THEIR ADOLESCENT'S MENTAL HEALTH AND PARENTAL USE OF ALTERNATIVE INTERVENTIONS

by

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Dissertation

Presented to the Faculty of the Graduate School of

The University of Texas at Austin

in Partial Fulfillment

of the Requirements

for the Degree of

Doctor of Philosophy

The University of Texas at Austin

December 2009

Dedication

This dissertation is dedicated, first and foremost, *a mis padres.* With your love and support, I always knew anything was possible. And to my dear husband, Will. You have always been my most enthusiastic supporter, and your strength and love has carried me through the toughest and the best of times.

Acknowledgement

I would like to express my sincerest gratitude to my co-supervisors, Dr. Deborah Tharinger and Dr. Richard Valencia, for the countless hours spent guiding me through this process. The unique perspectives they each brought to this research project were invaluable. I would also like to express appreciation to my committee members, including Dr. Ed Emmer, Dr. Michele Guzmán, and Dr. Elizabeth De La Portilla for their insight and input. In addition, I would like to thank Dr. Lisa Lasater and all the staff at my participating school district for all of their support and assistance in the completion of this project. I would especially like to acknowledge the participants who selflessly gave of their time, hearts, and minds. I have been enriched professionally and personally for having known each and every one of them.

I would also like to thank *mi familia* for being the biggest cheerleaders I could have ever hoped for. I am so blessed to have brothers and sisters like you. Thanks are also due to my *comadre*, Amy Hamilton, who encouraged me on a daily basis to stick with it, even when things looked bleak. Your "check-in" phone calls made all the difference in the world! And thanks to all my friends and colleagues for being there for me so many times and in so many ways.

MEXICAN AMERICAN PARENTS' BELIEFS ABOUT THEIR ADOLESCENT'S MENTAL HEALTH AND PARENTAL USE OF ALTERNATIVE INTERVENTIONS

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The Mexican American population is the largest and fastest growing Latino subgroup in the United States. Research has indicated Mexican Americans experience as many, if not more, mental health problems as other ethnic groups, including anxiety, depression, agoraphobia, simple phobia, drug and alcohol abuse, and increased rates of suicide. Mexican Americans, however, are among some of the most underserved by the mental health community. Little research, however, has focused on parents' beliefs about their adolescents' mental health, their utilization of mainstream mental health services, or their use of alternative resources for addressing their adolescent's problems. This is particularly troubling given Mexican American youth have disproportionately high rates of substance abuse, delinquency, depression and suicide. Mexican American youth's utilization patterns mirror those of adults, with lower rates of utilization than their peers of other ethnicities, and higher rates of early termination of treatment.

The purpose of this qualitative study was to examine a number of topics related to Mexican American mothers' perspectives on adolescent mental health, including factors

that contribute to problems, steps parents would be willing to take to help their adolescent, their beliefs about the use of mental health professionals, and their use of alternatives such as *curanderos*, priests, or family reliance to address their adolescent mental health problems. Participants were 27 mothers of adolescents who identify themselves as being of Mexican descent (Mexican; Mexican American). Mothers who agreed to participate were interviewed in person using a semi-structured interview format. The results revealed considerable consistency in the participants' views regardless of family history, adolescent problems faced, language spoken, and their generation in the U.S. The results of this study indicated that the Mexican American mothers who participated were attuned to adolescent functioning, with a keen sense for determining whether their adolescent is experiencing problems. The participants were able to navigate a complex system that involved considering other resources in their surroundings to address their adolescent's problems. Overall, participants indicated positive regard toward the use of family, church, schools, and professionals in helping their adolescent, while the use of traditional folk healers, such as *curanderos*, was only minimally indicated.

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CHAPTER 1: Introduction

The Mexican American population is the largest and fastest growing Latino subgroup in the United States (Guzmán, 2001), and as such this group deserves to have attention drawn to their specific, unique mental health needs. Research has indicated Mexican Americans experience as many, if not more, mental health problems as other ethnic groups, including anxiety, depression, agoraphobia, simple phobia, drug and alcohol abuse, as well as increased rates of suicide (Flaskerud, 1986; Karno, Golding, Sorenson, & Burnham, 1988; Karno, 1987; Leong, Wagner, & Tata, 1995; Wells, Hough, Golding, Burnam, & Karno, 1987; Woodward, Dwinell, & Arons, 1992). Mexican Americans, however, are among some of the most underserved by the mental health community (Padgett, Patrick, Burns, & Schlesinger, 1994a). Researchers have addressed questions regarding factors affecting adult Mexican American's lower rates of utilization of mental health services, as well as their attitudes toward traditional, western mental health services.

Little research, however, has focused on parents' beliefs their adolescents' mental health, their utilization of mainstream mental health services, or their use of alternative resources for addressing their adolescent's problems. This is particularly troubling given Mexican American youth have disproportionately high rates of substance abuse (Center for Disease Control and Prevention, 2002), delinquency (Poe-Yamagata & Jones, 2000), depression and suicide (Roberts, Roberts, & Chen, 1997). A better understanding of these

problems is crucial if the mental health needs of Mexican American children are to be addressed in a meaningful, effective, and culturally sensitive manner.

Research on the use of mental health services by Mexican Americans has indicated lower rates of utilization, as well as higher rates of early termination from treatment compared to their European American counterparts (Echeverry, 1997; Prieto, McNeill, Walls, & Gomez, 2001). Mexican American youth's utilization patterns mirror those of adults, with lower rates of utilization than their peers of other ethnicities (Bui & Takeuchi, 1992), and higher rates of early termination of treatment (McCabe, 2002; McCabe et al., 1999). A variety of factors are recognized as influencing access and barriers to services, including educational attainment, legal status, and language (Cuellar, Siles, & Bracamontes, 2004; Echeverry, 1997; Flaskerud, 1986). Other factors, such as stigma, religious beliefs, or use of alternative services, have also been hypothesized as affecting utilization patterns of Mexican American adults (Briones et al., 1990; Leong et al., 1995; Woodward et al., 1992).

Beliefs about mental health also play a pivotal role in the services Mexican Americans seek and receive in times of need. Stigmatic attitudes toward mental health problems, for example, appear to strongly impact the decisions to seek mental health services in times of need (Alvidrez, 1999; Flaskerud, 1986; Leong et al., 1995). Other reasons to not seek mental health services, however, can stem from differing sets of cultural values. Many Mexican American families traditionally espouse values of solving problems within the family system, and may opt to forego services offered by mental health care professionals (Alvidrez, 1999; Echeverry, 1997; Edgerton & Karno, 1971;

Flaskerud 1986; Harris, Velásquez, White, & Renteria, 2004; Jaco, 1959; Leong et al., 1995). Belief in God and the spiritual also influences use of mental health services in many Mexican Americans who believe mental health problems to be divine punishment or best addressed with the help of clergy (Lafitte, 1983).

Related to the aforementioned belief in God or the spiritual, some adults and parents within the Mexican American community may turn to alternative forms of treatment such as seeking the services of folk healers (Harris et al., 2004; Koss-Chioino, 2000). While different Latino cultures have their own, unique folk healing methods, some Mexicans and Mexican Americans are known for their practice of *curanderismo*, which blends ancient indigenous Mexican traditions with Catholic beliefs (Cervantes & Ramírez, 1992; Koss-Chioino; Trotter & Chavira, 1997). These healing practices are used to address a variety of health and psychological problems, including those believed to be the cause of evil forces (Harris et al.; Koss-Chioino; Trotter & Chavira). Several researchers have documented use of this alternative by Mexican Americans, including Jaco (1959) who first provided a detailed description of practices by Mexican Americans in Southern Texas and their use of *curanderos.* Other research has specifically indicated the use of *curanderos* by Mexican American mothers seeking help for their children (Kay, 1977; Rivera, 1988; Rivera & Wanderer, 1986). However, despite assertions that *curanderismo* continues to be a popular alternative to treatment via more mainstream means (see Harris et al., 2004), little research has emerged in the last two decades to confirm and describe its continued use.

The purpose of this exploratory study is to examine the following topics related to Mexican American mothers' perspectives on adolescent mental health: a) their beliefs about adolescent mental health and the factors that contribute to problems, b) the steps parents are willing to take to help their adolescent with problems, c) their beliefs about the use of mental health professionals, and d) their use of alternatives such as *curanderos*, priests, or family reliance to address their adolescent mental health problems. A qualitative method known as grounded theory (Strauss & Corbin, 1998) is used to develop a theoretical framework that captures the experiences and beliefs of the participants. Participants include 27 mothers who identify themselves as being of Mexican descent (Mexican; Mexican American), and whose adolescent child was enrolled in a participating central Texas school district. (Bogdan & Biklen, 2003). All interviews were then transcribed, and the transcripts were analyzed according to the grounded theory methodological approach developed by Strauss and Corbin.

This dissertation is organized into six chapters. The second chapter presents a review of the research literature pertaining to multicultural issues in mental health, the Mexican American population and their beliefs about mental health, utilization patterns, and use of alternatives, as well as mental health issues of Mexican American youth. Chapter 3 contains a description of the methodology used to guide data collection and analysis. Chapter 4 presents six descriptive summaries of participants, while Chapter 5 delineates the findings that emerged over the course of the study. Lastly, Chapter 6 is a discussion of results of this study.

CHAPTER 2: Review of the Literature

The purpose of the following integrative analysis is to provide an overview of the literature related to the current investigation. This analysis begins with a review of multicultural issues in mental health. Following is an introduction to the Mexican American population, including demographic information, and an overview of their characteristics as a whole. In addition, their beliefs about mental health and their utilization patterns will be described. Mexican American's use of alternatives for mental health problems is also discussed. Finally, a discussion of mental health problems in youth, and Mexican American youth in particular, is provided.

Multicultural Issues in Mental Health

Considering Mental Health Needs Through a Multicultural Lens

The term "melting pot" tends to be a popular descriptor of U.S. culture. If one takes a closer look, however, one would have to acknowledge that the U.S. is a place where many different cultures exist within a White majority context. With this consideration in mind, multicultural psychology has been defined as "the systematic study of all aspects of human behavior as it occurs in a setting where people of different backgrounds encounter one another" (Mio, Barker-Hackett, & Tumambing, 2006, p.12). Furthermore, a multicultural point of view assumes there are differences among groups, and that these differences are seen in their traditions, ways of living, worldview, and even language spoken (Mio, Barker-Hackett, & Tumambing; Jones & Korchin, 1982). With regard to psychology, a close look would reveal that ethnic minority groups in the U.S. differ from the majority in the ways they express psychopathology, especially through

culture-bound syndromes, their beliefs regarding the origin of illnesses, as well as their pattern of utilization of mental health services (Mio, Barker-Hackett, & Tumambing).

Culture-Bound Syndromes

The *Diagnostic and Statistical Manual of Mental Disorders IV-Text Revision* (DSM-IV-TR) (American Psychiatric Association, 2000), the source primarily used by mental health care providers in the U.S., has made updates over the years that recognize the unique expression of psychopathology of ethnic minorities. This can be seen in recommendations for culturally relevant considerations for Western psychopathology, outlines for cultural formulations, as well as discussion of culture-bound syndromes. Culture-bound syndromes are defined as group-specific patterns of behavior that differ from conventional Western psychiatric diagnoses (Simmons & Hughes, 1993). In addition, culture-bound syndromes are considered folk diagnostic categories that are "based in large part on locality-specific ideas of personhood, autonomy, vital essence, supernatural beings, illness, transgression, and health- in short, the matter and the forces that constitute the experienced universe," (Simmons & Hughes, 1993, p.76). For this reason, different cultures have different beliefs regarding the etiologies, or roots, of their culture-specific disorders.

For example, among African American cultures, etiology of illness can stem from natural and unnatural causes (Koss-Chioino, 2000). Illnesses attributed to natural causes include those resulting from God's plan, particularly when a person fails to serve Him. Unnatural illnesses can be caused by excessive worry, evil, sorcery, and magic. Culture-

bound syndromes unique to African Americans can include voodoo death, isolated sleep paralysis, and brain-fag syndrome (brain tiredness) (Iwamasa & Pai, 2003).

Within the Latino community, there are also some underlying beliefs that overlap the different subgroups. These can include the belief that malicious spirits or forces are the causes for physical, emotional, or personal problems (Koss-Chioino, 2000). In fact, there are few distinctions between these three types of problems. Culture-bound syndromes common in Latin communities include *ataques de nervios* (a stress-related reaction), and *susto* (extreme fright) (Iwamasa & Pai, 2003).

Just like the Latino community, the term Asian American covers a number of nationalities, including Chinese, Japanese, Vietnamese, and Korean, among others. Although each has its own beliefs and practices, there is some overlap in basic tenets, much of which has roots in Chinese medicine (Koss-Chioino, 2000). Illness is believed to step from inner causes, such as emotions, or outer causes, which include six evils. Imbalances in these inner and outer causes are believed to lead to illness. Some cultures also believe in the use of magic or sorcery to cause illness. Some illnesses unique to Asian Americans include *hwa-byung* (an abdominal pain), wind illness (an extreme fear of cold and the wind), and *koro* (an intense fear the penis will shrink) (Iwamasa & Pai, 2003).

Ethnicity and Western Psychological Disorders

In addition to culture-specific syndromes, ethnic minorities in the U.S. are also experiencing disorders that are also common in Western psychology. For example, the lifetime prevalence of depression as studied in the Epidemiologic Catchment Area (ECA,

an NIMH-funded program for the collection of psychiatric epidemiologic surveys) was revealed to be similar for Whites, Blacks, Asians, and Latinos (Zhang & Snowden, 1999). Other researchers and reviewers have also described similar rates of anxiety disorders, posttraumatic stress syndrome, personality disorders, and alcohol abuse among various ethnic groups and Whites alike (Al-Issa & Ouidji, 1998; Boehnlein & Kinzie, 1995; Helzer, Burnham, & McEvoy, 1991). Other research, however, has also revealed that in some instances certain ethnic minorities are experiencing higher rates of disorders compared to Whites or other minorities. For example, African Americans have been reported to experience higher rates of anxiety disorder than other populations, are more likely to have simple phobias than Whites, and have higher comorbidity rates with anxiety and other illnesses (Snowden, 1999). Other studies have reported higher rates of depression among Asians and Latinos (Hymes & Akiyama, 1991; Muñoz, Boddy, Prime, & Muñoz, 1990; Vega et al., 1998).

Utilization of Services and Unmet Needs

Despite similar, if not higher, rates of disorder among ethnic minorities compared to Whites, it has been recognized that minorities typically have unmet mental health needs (Jones & Korchin, 1982; Mio, Barker-Hackett, & Tumambing, 2006; Miranda, Lawson, & Escobar, 2002). Some factors that contribute to lower utilization include lack of medical insurance, language barriers, lack of culturally sensitive care, educational attainment, legal status, and distrust of the health care system (Brown, Ojeda, Wyn, & Levan, 2000; Echeverry, 1997; Manderscheid & Barrett, 1987; Sue, Fujino, Hu,

Takeuchi, & Zane, 1991). These issues will be discussed later in greater detail with regard to the Mexican American population.

The Mexican American Population: Culture and Context

Definitions

Before initiating a discussion on the Mexican American population, a brief review of terminology and definitions is warranted. First, the term "Hispanic" needs to be understood in its historical context, which has roots in the United States Bureau of the Census. Every 10 years, the U.S. Census collects data regarding general, social, economic, and housing characteristics. One type of data includes race, which is broken down by whether a person considers themselves to be White, Black/African American, American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, some other race, or a combination of two or more races. The other related data pertains to whether a person is Hispanic or Latino, which the Census Bureau considers a distinct concept from race, and is related instead to whether the person is of Spanish heritage.

The term Hispanic was adopted by the Census Bureau as a way to identify persons of Spanish heritage. These can include people with Mexican, Puerto Rican, Cuban, Central and South American roots, as well as others of Spanish descent. The term was first used in the 1970 census, with the purpose of collecting data needed for implementation of federal statutes, including enforcement of bilingual election rules under the Voting Rights Act, as well as the enforcement of equal employment opportunities under the Civil Rights Act (U.S. Census Bureau, 2006). While the term Hispanic is widely used, it is often criticized for its lack of recognition of the indigenous

roots of many of the people it describes. For this reason, the term "Latino", which refers to people of mixed Native American and Spanish descent, has been used as an alternative to represent this group, which is of mixed racial heritage (Rochín & de la Torre, 1996).

Within the group of Latinos who identify themselves as having Mexican roots, there is also debate regarding labels. The terms Mexican, Mexican American, and Chicano can be used in different contexts, and carry different meanings. While a Mexican American is typically considered a United States citizen of Mexican ancestry, the term Chicano can be used to reflect, "pride in the indigenous roots of the Mexican people," (Hall, 2005, p. 28). This particular term became popular with political activists in the 1960s and continues to be used as a way to imply one's political status. The term, however, must be used carefully and it is recommended that a person who is not a member of the culture use the term Mexican American (Hall). Throughout this text, the term Mexican American will be used to describe Mexicans in the U.S., while the term Latino will be used to describe all people of Latino heritage, including Mexican Americans. In addition, the terms European American and White will be used interchangeably, as will African American and Black.

Demographic Overview of Mexican Americans in the U.S.

As a group, Mexican Americans possess unique characteristics that distinguish them from other ethnic groups in the U.S. Mexican Americans comprise the largest subgroup of Latinos in the United States, almost two-thirds of the 35.3 million Latinos as of the latest census in 2000 (Guzmán, 2001). They are also the fastest growing Latino subgroup, with an increase of 52.9% since 1990, compared to an increase of 13.2% of the

general population. The largest populations are concentrated in California, Texas, Illinois and Arizona, with New Mexico having the highest percentage of the total population. Counties along the border with Mexico have the highest proportion of Mexican Americans (Guzmán).

Census data from 2000 also indicated that four times as many Mexican American families were living in poverty compared to their non-Hispanic White counterparts; 40% of Mexican American children were reported living below the poverty line. Mexican Americans are also younger than the rest of the population, with 38.4% being under the age of 18, with a median age of 24.2. This contrasts with 25.7% under the age of 18 for the general population, with a median age of 35.5 (Aponte & Crouch, 2000).

With regard to educational attainment, Mexican Americans are among the least educated of all the Latino subgroups in the United States. Historically, only half of all Latinos complete high school, and even less enter and complete college (Aponte & Crouch, 1995; O'Brien, 1993; Solberg, Valdez, & Villarreal, 1994; Zea, Jarama, & Trotta Bianchi, 1995). A more detailed discussion on the school failure of Mexican American students is covered in a later section.

The Mexican American Family

Census data also indicate Mexican American families parallel European American families in the proportion of two-parent households, with nearly two-thirds being two-parent households. Unlike European Americans, Mexican Americans are likely to have a larger household size, averaging 4.5 family members. Data collected by the U.S. Census Bureau, however, does not reflect the interconnectedness of extended

family. In many Mexican American families, extended members, including grandparents, aunts, uncles, and cousins, are a vital part of the family (Falicov, 1996; Ramírez, 1998). These extended members play an integral role in family functioning through help in parenting, education, and in the transmission of religious beliefs. This reflects the concept of *familismo,* which puts emphasis on interdependence, not independence (Falicov). As such, Mexican American families tend to have strong family ties. In addition to blood relatives, the Mexican American family has a strong reliance on *compadres,* or godparents, turning to them for emotional and social support (Falicov; Ramírez).

Within traditional Mexican American families, there can be seen a pattern of gender dictating members' roles within the family. Males and females are taught very different rules of behavior, starting at a very young age, through explicit instruction and by example. Men are expected to be strong, authoritarian, independent and brave; women are expected to be sentimental, docile, submissive and dependent on men (Falicov, 1996). Furthermore, the mother is typically the foundation of spiritual faith, and is most likely to resort to using resources within the community, including the church and alternative healing methods (Falicov; Flaskerud, 1986; Harris et al., 2004).

History of Mental Health Service Utilization by Mexican Americans

Help-seeking: Access and barriers to mental health services

In the past few decades, literature on use of mental health services by Mexican Americans has reflected lower rates of help-seeking when compared to European Americans (Echeverry, 1997; Flaskerud, 1986; McCabe, 2002; Prieto et al., 2001). Furthermore, those who do seek services tend to have higher early termination rates.

While some researchers have suggested this discrepancy is due to lower rates of mental health problems within the Mexican American community (Cuellar et al., 2004; Jaco, 1959), this claim has historically been refuted by researchers who have found similar, or higher, levels of mental illness as in other ethnic groups (Flaskerud, 1986; Leong et al., 1995; Wells et al., 1987; Woodward et al., 1992). Epidemiological research has found that Mexican Americans presented with higher rates of generalized anxiety disorder, agoraphobia, simple phobia, as well as alcohol and drug abuse (Karno et al., 1987).

A number of factors have been postulated to affect help-seeking, including demographic characteristics (e.g., gender, educational attainment, and legal status), cultural factors (e.g., religious beliefs, acculturation, and English proficiency), as well as organizational variables (e.g., location and cost of services; personnel language) (Echeverry, 1997). Demographic characteristics such as gender, education, and legal status affect help-seeking in a number of ways. Gender is believed to be a barrier for men who believe seeking mental health services is emasculating, or is a sign of weakness and therefore they eschew services (Casas, Wagenheim, Banchero, & Mendoza-Romero, 1994; Rivera, 1988). Latinas have been hypothesized as underutilizing mental health services because of their reliance on family to assist with problems (Alvidrez, 1999). Traditional gender roles, and the relative position of women in the Latino community, are also thought to affect utilization via women's lower educational levels and socioeconomic status (McNeill et al., 2001). Others, however, have suggested that Mexican American women are more likely to at some point in their lifetime to show

higher levels of mental health problems, such as depression, and will thus more readily seek mental health treatment (Briones et al., 1990).

Educational level is thought to be a factor in help-seeking through its relation to knowledge of available resources (Echeverry, 1997). This impacts the Latino community because, as discussed previously, Latinos have the lowest levels of education of all ethnic groups in the country (Aponte & Crouch, 1995; O'Brien, 1993; Solberg et al., 1994; Zea et al., 1995). Researchers have discovered that less educated Mexican Americans indeed have more limited awareness of available services, and therefore seek them less than other groups (Briones et al., 1990; Leong et al., 1995).

Legal status is an important factor affecting help-seeking due to perceived access problems that can arise in making contact with service providers (Echeverry, 1997). Undocumented immigrants may avoid seeking services because of fear it will lead to their identification and deportation. Despite the fact that many federally funded programs do not ask potential clients about their legal status, many undocumented immigrants are still distrustful, and therefore avoid seeking services (Echeverry).

Cultural factors, such as level of acculturation, religious beliefs, and language, have also been identified as affecting Mexican Americans' use of mental heath services (Briones et al., 1990; Leong et al., 1995). There are several ways in which acculturation could affect help-seeking; some evidence indicates that Mexican Americans who hold traditional values suffer from less psychological problems than Mexican Americans who reject these traditional values, suggesting that cultural assimilation into mainstream American values may not be conducive to Mexican Americans' psychological welfare

(Rodriguez, Ramírez, & Korman, 1999). Other research has suggested the opposite, finding that people who most successfully acculturate show less psychological distress than those who did not successfully acculturate (Neff & Hoppe, 1993). Regardless of acculturative connections to psychological problems, researchers agree that low levels of acculturation are associated with low help-seeking rates, attributed to lack of understanding about mental health treatment and available resources (Echeverry, 1997; Wells et al., 1987).

Religious beliefs may represent a barrier when people espouse beliefs that difficulties in life, including illness and mental health problems, are God's will (Smart & Smart, 1991), and that such problems should be put in God's hands (Woodward et al., 1992). As discussed previously, because of the high incidence of Catholicism within the Mexican American community, it is expected that spiritual leaders or church attendance might be relied upon instead of mental health services.

Limited English proficiency is also believed to reduce the likelihood of seeking mental health services (Briones et al., 1990). According to González (1997), the majority of Mexican Americans consider themselves Spanish-speaking or bilingual (in degrees), which may pose a problem for treatment delivery when language barriers exist between patient and care provider (Woodward et al., 1992).

Utilization Patterns

Part of the lower rates of utilization of mental health services by Mexican Americans is part of lower health service use in general (Woodward et al., 1992). Despite the fact that the Latino population is diverse, much of the literature treats them as a

whole, without differentiating between Mexican Americans, Puerto Ricans, Cubans, and other Latino subgroups. This is similar to what happens with Asian Americans populations who also tend to be grouped as a whole (Barreto & Segal, 2005). This is sometimes the result of researchers seeking ease of comparisons to other groups, such as African Americans, European Americans, or other ethnic groups. This homogeneous grouping can also be the result of inappropriate generalization of all Latinos. For these reasons, some of the information available refers to Mexican Americans as well as other Latino groups.

Several national health surveys indicate Latinos are less likely to utilize mental health services than European Americans (Casas, 1984; Echeverry, 1997; Padgett et al., 1994a; Sue, Zane, & Young, 1994; Treviño & Moss, 1984). While there are numerous factors affecting utilization, as previously discussed, some studies have attempted to control for some of them have found there is still a difference in mental health care utilization. For example, two studies by Padgett and colleagues (1994a; 1994b) showed that Latinos with identical health insurance coverage are still less likely than their European American counterparts to use mental health services. Similarly, White Medicaid patients are more likely than their Latino counterparts to use outpatient psychiatric services, with the exception of alcohol treatment programs (Temkins-Greener & Clark, 1988).

More recent studies continue to reflect a trend of underutilization of mental health services by Latinos. In a study on young women's service use, Alvidrez (1999) interviewed 217 Latina, African American, and White women about their use of mental

health services and found that a smaller percentage of Latinas (11%) reported prior use mental health services, compared to African Americans (36%) and White women (58%). Furthermore, fewer Latinas (17%) reported use of mental health services by friends or family, compared to African Americans (33%) and White women (63%). Similar results have been reported by a number of researchers (Harris et al., 2004; Kimberling & Baumrind, 2005; Wells et al., 2001).

Utilization of Mental Health Services by Mexican American Youth

Minority children show patterns of utilization different from that of White children. This mirrors patterns of utilization by adults as found by a number of researchers discussed previously (Casas, 1984; Echeverry, 1997; Padgett et al., 1994a; Sue, Zane, & Young, 1994; Treviño & Moss, 1984). A study by Bui and Takeuchi (1992) examined rates of utilization and treatment dropout of African Americans, Asian Americans, Hispanics, and Whites, finding that Mexican Americans were underrepresented in using mental health services. A more recent study by Yeh and colleagues (2005) found that Latino youth were less likely than non-Hispanic Whites to use mental health services even when controlling for demographic variables and severity of symptoms. Latino youth are also more likely to terminate early, with as many as 60% to 75% dropping out after the first treatment session (McCabe et al., 1999).

Mexican Americans' Beliefs about Mental Health

Belief in the Spiritual and God

Mexican Americans are believed to have strong connections to the spiritual, religion, and God. It has been estimated that nearly 90% of Mexican Americans have

strong Catholic roots (Falicov, 1996). This is particularly important when dealing with Mexican Americans and their mental health problems because there is a strong tendency for disabilities to be viewed as supernatural in origin, or to be interpreted as divine punishment for sin (Smart & Smart, 1991). God is considered a central part in the cause of suffering (Koss-Chioino, 2000).

In order to address these disabilities with divine roots, Mexican Americans turn to God, the Virgin Mary, and saints to help. In an early survey of Mexican Americans in California, Padilla, Carlos, and Keefe (1976) found that 17% of respondents reported seeking the help of a priest, higher than the 14% who reported seeking out a mental health clinic, and the 9% who would seek a counselor. This has been supported by a number of studies in which Mexican families reported turning to clergy to address personal and psychological problems (Padilla et al.).

In addition to counting on clergy, Mexican Americans rely on their faith in the Virgin Mary, or *La Virgen de Guadalupe,* the patron saint of Mexico (Harris et al., 2004). Traditionally she is considered a helper, guide, and protector (Lee, 1947; Watson, 1964), and continues to hold a special place in Mexican Americans' belief system (Harris et al.; Rodriguez, 1994). Watson (1964) has suggested *La Virgen de Guadalupe* is seen as a link between God and mankind, and is therefore seen as an intercessor in times of need. For this reason she is not directly asked for help, but rather is expected to pray for her people, and it has been suggested people place as much trust and faith in her as in God (Harris et al.).

Family Reliance

Within the Mexican American community, families have long been known to be a valuable resource when someone is suffering from stress, emotional problems, or maladaptive behavior (Harris et al., 2004). In a classic study of Mexican Americans in South Texas, Jaco (1959) found that families tended to provide significant support to other members in their times of need, including during times of psychological distress. He found that one key role the family can play is in providing comfort, support, and love to the person suffering. Other researchers have also found that Mexican Americans believe mental health problems are best taken care of within the family (Edgerton & Karno, 1971). In a more recent study, Alvidrez (1999) also found that Latinas were more likely than African American and White women to believe psychological problems should be talked about only within the family. This has been corroborated in studies that show Mexican Americans are more likely to rely on family support than turn to mental health professionals when experiencing distress (Echeverry, 1997; Leong, 1995). Furthermore, Briones and colleagues (1990) have found that Mexican Americans who report using family as support show reduced levels of depression.

Within the family system in general, it is typically the mother who provides the psychological support in times of need and who collaborates with other females in the family to provide support during times of need (Harris et al., 2004). They are there to offer words of wisdom, support, and console the person in need. Family members are also confided in to give advice and provide guidance (Flaskerud, 1986). Other researchers have found that Mexican Americans are also likely to turn to relatives, such as

compadres, as a source during times of distress at a higher rate than seeking out a mental health provider (Padilla et al., 1976).

Stigma

Researchers have found evidence that mental illness has a stigmatic connotation attached to it within the Mexican American community (Malgady, Rogler, & Constantino, 1988). These stigmatic attitudes have been linked to underutilization of mental health services. In a study by Silva de Crane and Spielberger (1981), Latinos were found to have more negative views of mental illness compared to non-Hispanic Whites. Other studies report similar findings, which suggest Mexican Americans associate mental health problems and help-seeking with shame, and consider psychological problems as a sign of weakness (Flaskerud, 1986; Leong et al., 1995).

The stigma associated with mental health problems has also been blamed for the early termination of treatment (Levine & Padilla, 1980). A recent study by McCabe (2002) studying factors that predict early termination of mental health services for Mexican American youth did not find a connection to stigma, but raised the question of whether stigma caused the exclusion of people espousing those beliefs, thus positing stigma impacts service entry, not retention.

Mexican American Parents' Beliefs About Adolescent Mental Health

Bui and Takeuchi (1992) recognized that there is a need for community studies of ethnic minority youth to document help-seeking behaviors. They also noted that parent attitudes and beliefs about mental health could be a barrier in help-seeking. However, little research has been carried out to examine Mexican American parents' beliefs about

mental health and attitudes toward treatment, and that which has been conducted has focused on parents who have already sought treatment (McCabe, 2002; Yeh et al., 2005), and completely overlook attitudes and beliefs of those who do not seek treatment. This leaves a considerable gap in the literature base of Mexican American parents' attitudes and beliefs that needs to be addressed.

Alternative Resource Theory

Because beliefs in the spiritual, family reliance, and shame have been linked to Mexican American's underutilization of mental health services, as well as their use of alternatives, researchers have developed an "alternative resource theory" (Leong et al., 1995, p. 426). This theory is based on an assumption that Hispanics come from a culture that makes use of different methods of treatment to address psychological problems (Woodward et al., 1992), including family, friends, folk healers, or religious leaders (Flaskerud, 1986; Keefe, Padilla, & Carlos, 1976).

The alternative resource theory has received support from research that has shown use of these alternative resources (Alvidrez, 1999; Guendelman & Schwalbe, 1986; Leslie & Leitch, 1989). It is believed these alternatives continue to be sought because they provide some relief to people during times of distress. Researchers found that among Latinos with similar levels of stressful life events, the likelihood of psychological distress and subsequent use of mental health services decreased as use of social support increased (Goodman, Sewell, & Jampol, 1984). Because the use of family and religious leaders has previously been addressed, the discussion now turns to the Mexican American tradition of folk healing known as *curanderismo.*

Traditional Folk Healing Approaches

Different Latino cultures have their own folk healing practices and methods. Generally speaking, Puerto Ricans ascribe to *espiritismo,* Cubans to *santería*, and Mexicans to *curanderismo*, each derived from the incorporation of European and Catholic traditions with indigenous practices (Cervantes & Ramírez, 1992; Koss-Chioino, 2000; Trotter & Chavira, 1997). While a detailed description of all folk healing methods is beyond the scope of this review (the interested reader may turn to Harris et al., 2004 and Koss-Chioino), a more in-depth view of the practices by Mexican Americans is warranted.

The word *curanderismo* has its origins in the Spanish word "curar," which means, "to heal" (Trotter & Chavira, 1997). Those who practice are referred to as *curanderos* or *curanderas.* The Mexican government has defined the traditional Mexican practice of *curanderismo* as a "system of knowledge, beliefs and practices which are intent on the prevention and treatment of illnesses or the management of causes of misbalance, which is perceived as pathological for the individual or the social group," (Instituto Nacional Indigenista/Secretaria de Salubridad y Asistencia, 1993, p. 45). Because *curanderismo* is a synthesis of Catholic beliefs and indigenous Mexican traditions, illnesses and their causes are regarded differently than in the Western tradition. A *curandero* typically treats ailments such as *mal de ojo* (the evil eye), *susto* (extreme fear), *nervios* (anxiety), *envidia* (extreme jealousy), or *embrujo* (hex) (Harris et al., 2004; Koss-Chioino, 2000; Trotter & Chavira, 1997). The *curandero* is considered a very important person in the community,

particularly because it is believed they receive their healing powers as a gift from God (Koss-Chioino; Trotter & Chavira). They typically develop this gift through an apprenticeship with an established *curandero*, often from the same family. *Curanderos* are given such cultural authority by the community that they are seen many times working side by side with physicians (Harris et al.), particularly in prescribing over-the-counter herbal remedies or vitamins (Koss-Chioino; Trotter & Chavira).

It is important to note, however, that the use of folk healers is not unique to Mexican Americans, but rather is seen in cultures all over the world. In the U.S., researchers have studied folk beliefs in African Americans, Greek immigrants and various Latino groups (Harris et al., 2004). However, very little epidemiological data is available on the utilization of folk-based treatment by Mexican Americans.

Some studies have reported the use of *curanderos* by a small percentage of Mexican Americans in California (Chavez, 1984; Gilbert, 1980; Keefe, 1981). Their studies, however, did not tap into a representative sample of the population. Some reports have indicated utilization rates as high as 54%. In a survey of 128 Hispanic American women in Colorado, Rivera (1988) found that 20% of all women had visited a *curandero*, and that 1 out of every 8 had taken their child to a *curandero* for treatment of illnesses. This mirrors previous research from Rivera and colleagues (1986), and Kay (1977), who also found Hispanic women were likely to have indigenous beliefs. In a more recent study, Sleath and Williams (2004) examined the relationship between Hispanic ethnicity and patient use of alternative treatments for depression. Hispanic and non-Hispanic White patients meeting DSM-III-R criteria for major depression, minor depression or dysthymia

were asked whether they sought alternative treatment. Of the 141 participants, 36% reported talking with a religious person, 17% used herbal remedies, and 5% had seen a *curandero.* This study, however, did not compare the difference between Hispanics and non-Hispanics.

While scholars acknowledge the continued study of *curanderismo* (see Harris, 1998; Harris et al., 2004), newer research has not focused on utilization, but rather on ways to incorporate indigenous beliefs into therapy. Citing classic studies, such as those of Jaco (1959) and Kay (1977), researchers today acknowledge the relevance of folk healing beliefs of Mexican Americans, without providing evidence of its continued use or endorsement by the community. This is also true for their use specifically for adolescent problems.

Mental Health Issues in Youth

Developmental Psychopathology: An Overview

Our current understanding of children's mental health, as well as their problems, is based on the assumption that a multitude of factors interact to produce these outcomes. While a number of investigators have developed various guiding principals by and large it is accepted that childhood psychopathology arises from the interaction between individual factors and the environmental factors (Cicchetti & Cohen, 1995; Jensen, 1998; Sroufe & Rutter, 1984). Individual factors include biological and genetic factors, while environmental factors can include family and peer relations, community factors and the larger social context. The ways these factors interact contribute to unique outcomes for each individual child.

While it is likely the genesis of childhood mental disorders lies in a combination of environmental and biological factors, more recently increasing attention has been given to the latter (Rutter, Silberg, O'Connor, & Simonoff, 1999). When considering the role of biological factors, however, one needs to be conscious of the difference between biological influence and genetics. Behaviors and emotions, for example, can be influenced by changes or abnormalities in central nervous system, infections, poor nutrition, or exposure to toxins (National Institute of Mental Health [NIMH], 1998). Disorders that are thought to have biological influences include social phobia, obsessive-compulsive disorder, and Tourette's disorder (Leckman, Peterson, Pauls, & Cohens, 1997; Leonard, Rapoport, & Swedo, 1997; Pine, 1997). In contrast, disorders that are inherited are considered to have a genetic component. These include autism, bipolar disorder, schizophrenia, attention-deficit/hyperactivity disorder, and depression (ADHD) (Kovacs, Devlin, Pollock, Richards, & Mukerji, 1997; NIMH).

Family has also been documented to affect mental health outcomes in youth. The effects of parental depression are widely documented and can include increased risk of anxiety disorders, alcohol dependence, and delinquency (Downey & Coyne, 1990; Weissman, Warner, Wickramaratne, Moreau, & Olfson, 1997; Wickramaratne & Weissman, 1998). These disorders are thought to be influenced by the depressed parent's lack of attention or supervision, their excessive irritability, or their distress, which may trigger fear, anxiety or depression in a child. Family can also affect children's mental health through physical or emotional abuse. Both forms of abuse have been associated with posttraumatic stress disorder, ADHD, conduct disorder, depression, as well as social

and cognitive impairment (Famularo, Kinscherff, & Fenton, 1992; Kaufman, 1991; Kazdin, Moser, Colbus, & Bell, 1985; Smetana & Kelly, 1989).

Mental disorders that can have onset at childhood, but which also apply across the entire lifespan, include anxiety and mood disorders, ADHD, autism and other pervasive developmental disorders, eating disorders, eliminating disorders, learning disorders, mood disorders, schizophrenia, and tic disorders (APA, 2000). In later childhood and adolescence, other disorders may emerge, including alcohol and drug abuse, anorexia or bulimia nervosa, bipolar disorder, conduct disorder, or oppositional defiant disorder. The assessment of disorders in children and adolescent usually consists of the gathering of information from the child, parents, teachers, and medical health care providers (Thomas & Holzer, 1999). Observations of the child's or teenager's behavior are also common, but some researchers have found that direct questioning yields more reliable information regarding symptomology (Gittelman, Mannuzza, Shenker, & Bonagura, 1985; Gittelman-Klein, 1978). Researchers have also developed questionnaires to aid in the diagnosing of disorders and in assessing personality function, such as the Children's Depression Inventory (Kovacs, 1985), the Reynolds Adolescent Depression Scale (Reynolds, 1986), the Family Interaction Coding Pattern (Patterson, 1982), the Child Behavioral Checklist (Achenbach & Edelbrock, 1983), or the Minnesota Multiphasic Personality Inventory-2 (Hathaway & McKinley, 1989).

With regard to the treatment of child and adolescent disorders, strategies typically include a form of psychosocial treatment, psychopharmacological intervention, or a combination of both. According to the American Academy of Child and Adolescent

Psychiatry (2004) treatment delivery can occur in a continuum from least restrictive to most restrictive including: outpatient; intensive care management; home-based treatment services; family support services; day treatment programs; partial hospitalization; crisis services; respite care; therapeutic group home; crisis residence; residential treatment; and hospital treatment.

While it has been estimated that approximately 6 to 9 million children and adolescents in the U.S. experiencing serious emotional problems (Friedman, Katz-Leavy, Manderscheid, & Sondheimer, 1996; Lavigne et al., 1996), it has been concluded that a high proportion of them are not receiving any type of mental health service (Burns et al., 1995; Leaf et al., 1996; U.S. Office of Technology Assessment, 1986). Furthermore, among those who do seek treatment, there is a high proportion that terminates prematurely (Kazdin, Holland, & Crowley, 1997). This has been attributed to the fact that these children and adolescents are receiving treatment as a result of referrals by schools, courts or other agencies, and not the clients or their families. Poverty has also been associated with both high dropout rates, and shorter treatment length (Hoberman, 1992). The child's cultural background is also believed to play a role in mental health care utilization, with Latino and African American children leaving services prematurely more so that White children (Bui & Takeuchi, 1992; Sue, et al., 1991). One of the main factors believed to affect utilization is mental health care providers' insensitivity to the cultural beliefs of clients and their families (Woodward et al., 1992).

Mental Health Problems in Mexican American Youth

Burt, Resnick, and Novick (1998) have developed a framework for understanding childhood risk for mental health problems that is ecologically comprehensive, emphasizing antecedent conditions, early signs of difficulty, and eventual negative outcomes. As described previously, Mexican Americans, and therefore Mexican American youth, exist in a context of poverty and acculturative stress, including language difficulties, which place them at increased risk for a variety of problems, including psychological disturbances. Early signs of problems in Mexican American youth include school failure and police records, which are disproportionately high in this population (Organista, 2003). These early signs are later seen in higher school dropout rates (Rumberger, 1998; Rumberger & Larson, 1994), risky sexual behaviors (Baumeister, Flores, & Marin Van Oss, 1995; Berry, Shillington, Peak, & Hohman, 2000), substance abuse (Center for Disease Control and Prevention, 2002, 2006), delinquency (Poe-Yamagata & Jones, 2000), depression and high suicide rates (Roberts, Roberts, & Chen, 1997).

School failure. The issue of school failure among Mexican American youth has received much attention and has been well documented (e.g., Valencia, 1991; 2002). School failure has been referred to as "*persistently, pervasively, and disproportionately, low academic achievement,"* (Valencia, 2002, p.4). This issue is of particular importance because of its potential to lead to further problems, especially in Mexican American youth. Rumberger and Larson (1994) found that Mexican American dropouts have some characteristics in common with other American dropouts in that they dislike school, have

low educational aspirations, and discipline problems. Mexican American youth, however, are more likely to dropout before reaching high school. In a review by Rumberger (1998), he found that 17% of Mexican American youth dropped out before reaching 9th grade, less than half of 9th graders were on track to graduate, and by the end of the 10th grade, 31% of Mexican American youth dropped out, with less than a quarter having enough credits to be on track to graduate. These dropout rates are attributable to the fact that Mexican American children are more likely to attend schools with low quality curricula, less qualified teachers, and poorly organized English proficiency programs (Solorzano & Solorzano, 1995). Furthermore, Latino youth have been reported to experience their school environment as hostile. The most recent report by the Center for Disease Control and Prevention (CDC) (2006) reveals that Latino students did not attend school because they felt it was unsafe at higher rates than their African American and White counterparts (10.2% versus 8.7% and 4.4%, respectively).

Risky sexual behavior. Risky sexual behavior is a problem that has continued to grow in the Mexican American community. In national surveys, risky sexual behavior has led to an increase in rates of teen pregnancy, which in turn leads to fewer education and career options, and higher poverty rates (Berry et al., 2000; Franklin & Corcoran, 2000). In its latest report, the CDC (2006) found that Hispanic youth exhibited some of the highest rates of risky behavior when compared to their African American and White counterparts. For example, Hispanic had the lowest rates of condom use and birth control pill use. Furthermore, Hispanic males were also most likely to have used alcohol or drugs before a sexual encounter than their African American or White peers. While lower than

their African American peer's rates, Hispanic youth were found to have high rates of having four or more sexual partners in their lifetime. Given these trends, it is not surprising that the CDC reports higher rates of teen pregnancy for Mexican American youth (93.2 out of 1000) than African Americans (64.7 out of 1000) or Whites (27.4 out of 1000) (Martin et al., 2005).

Substance abuse. The problem of substance abuse by Mexican American has become the subject of much research. A number of studies over the years have chronicled the continued increase of drug and alcohol by this population (e.g., Chavez, Randall, & Swaim, 1992; CDC, 2001, 2006). In the 1990's, research was indicating Mexican American youth were using alcohol and drugs at similar or lower rates than their White peers. The latest report by the CDC, however, shows a disturbing trend: Mexican American youth, particularly males, have higher lifetime rates of alcohol (79.9%), tobacco (62.1%) marihuana (47.7%), cocaine (14.9%), and illegal injection drug (4.6%) use compared to White and Black youth. Use of inhalants was second only to that of Whites.

Depression and suicide. In recent years, evidence has emerged indicating Mexican American youth are at greater risk for depressive disorders than their European American and African American counterparts (Organista, 2003). Doi, Roberts, Takeuchi, and Suzuki (2001) analyzed data on adolescents, ages 12 to 15, in the United States and Japan with the purpose of comparing rates of depression between the two countries. When comparing rates of depression among Anglo Americans, African Americans, Mexican Americans, and Japanese adolescents, Mexican Americans had the highest rates

of depression with and without impairment (9% and 16.9%, respectively), followed by African Americans (6.1% and 13.4%), Anglo Americans (4.3% and 9.6%) and Japanese adolescents (1.3% and 5.6%). A study by Roberts, Roberts, and Chen (1997) revealed that among 5,423 students in grades 6 through 8, rates of major depression with impairment were higher among Mexican Americans than any of the other eight ethnic groups, even after controlling for SES, gender, and age. These findings mirror evidence found by other researchers (Roberts, 1994; Roberts & Roberts, 1992; Weinberg & Emslie, 1987) who consistently found that Mexican American youth, and girls in particular, exhibit higher rates of depression than youth of other ethnicities in the United States.

Gangs and delinquency. The issue of delinquency among Mexican American youth is one that goes hand in hand with many of the topics that have been discussed. Delinquency and gang involvement overlap with issues of school failure, drug use, and mental health problems. Despite the fact that Latino youth make up only 15% of all youth in the U.S., they represent 18% of all juvenile delinquents (Poe-Yamagata & Jones, 2000). Furthermore, while there has been no systematic collection of gang related membership in the U.S., some researchers have estimated that gang membership in the U.S. is composed of Mexican American youth, including girls (Goldstein & Soriano, 1994; Harris, 1994; Poe-Yamagata & Jones). Some researchers argue that schools exacerbate the problem through segregation, academic tracking, and in the manner they address issues of delinquency (e.g., detention or suspension) (Felkenes & Becker, 1995; Harris; Vigil, 1999). These issues, along with the problems discussed with regard to

school failure, are likely to lead students away from schools, and out on the community where they are more likely to encounter problems leading to delinquency and gang involvement. Furthermore, the research of Belitz and Valdez (1997) has indicated that psychological crises, as well as general stress related to family and society, are likely to push youth into the gang culture, which is has a strong pull for vulnerable youth looking for a place to fit in. Involvement in gangs generally means worse outcomes for Mexican American youth compared to Mexican American youth not involved. Lyon, Henggeler, and Hall (1992) found that Mexican American youth in gangs were more likely to have long criminal records and higher reports of hard drug use.

Statement of the Problem

Research has shown a clear pattern of underutilization of mental health services by Mexican Americans (Bui & Takeuchi, 1992; Echeverry, 1997; Padgett et al., 1994a; Treviño & Moss, 1984, Sue et al, 1994). While some researchers have concluded underutilization stems from several barriers, including gender, educational attainment, legal status, religious beliefs, and acculturation, that keep Mexican Americans from the services they need, (Briones et al., 1990; Cuellar, Siles, & Bracamontes, 2004; Echeverry; Flaskerud, 1986), it has also been hypothesized that Mexican Americans are seeking alternatives, such as religious figures or folk healers, during their times of need (Alvidrez, 1999; Echeverry; Edgerton & Karno, 1971; Flaskerud; Harris et al, 2004; Jaco, 1959; Koss-Chioino, 2000; Leong at al., 1995; Trotter & Chavira, 1997). Little research, however, has studied these trends and patterns with regard to children and adolescents. There is a substantial gap in the literature regarding parents' beliefs about their

adolescent's mental health and the mainstream mental health services that are available to them, as well as parents' use of alternative resources in helping their adolescent. Given the wide array of problems and risks that Mexican American youth face today, it is imperative we begin to close this gap so as to address this group's mental health needs in a manner that is meaningful, effective, and culturally sensitive.

CHAPTER 3: Methodology

Research Design

Grounded Theory Approach

Qualitative methods are used to investigate areas that have not been explored much, or when a researcher is interested in capturing the experiences or thoughts of participants of interest. Qualitative methods typically do not make use of statistical methods to produce descriptive results (Bogdan & Biklen, 2003), but rather help develop theory about the concepts that are being investigated (Jacob, 1987).

Grounded theory is a qualitative method that begins as a description of a phenomenon and aims to give credit to it by a process of collecting, coding and analyzing data (Bogdan & Biklen, 2003). Through this process, the researcher moves into developing themes and concepts that are interrelated to form a theoretical framework that will explain the phenomenon. As theory emerges, it is continuously compared to old and new data to verify its fit. If these concepts hold up to such scrutiny, they are said to be validated as grounded theories.

Research Questions

In grounded theory, the initial research questions are considered to be starting points that are allowed to change as the study progresses. This allows the questions to remain grounded in the data and concepts that come into light. For this reason it is recommended the questions begin broad and proceed to be refined throughout the research process (Strauss & Corbin, 1998). The four questions that follow guided the data collection in the present study.

1. What are Mexican American mothers' beliefs about their adolescent's behavioral and emotional problems, and what are the factors that contribute to these problems?

2. What are mothers' help-seeking behaviors? What steps are they willing to take to help their adolescent with problems?

3. What are their beliefs about the use of mental health professionals?

4. What, if any, alternatives to mainstream mental health services are mothers using to address their adolescent's behavioral and emotional problems (e.g., *curanderos*, priests, or family reliance)?

Procedures

Background on Setting

The participants in this study were 27 mothers of Mexican American descent who had at least one adolescent child (between the ages of 12 and 17) enrolled in a public school district in Texas between Spring 2007 and Spring 2009. This is a public school district with a high percentage of students who are identified as Hispanic, most of whom are of Mexican American descent. It is comprised of seven elementary schools, two middle schools, one high school, one discipline alternative education program (or alternative center), and one alternative teaching and learning campus for students who have not been successful in a traditional high school setting.

During the 2007-2008 school year, the enrollment in the district, including Early Childhood Education and Pre-Kindergarten through 12th grade in all campuses, was

9,159. The distribution based on ethnicity was 76.4% Hispanic (*n*=7,000), 13.8% African American (*n*=1,262), 8.7% White (*n*=794), 0.9% Asian/Pacific Islander (*n*=82), and 0.2% Native American (*n*=21). Of the 9,159 students enrolled, 79.2% (*n*=7,257) were classified as economically disadvantaged, 27.5% (*n*=2,518) were classified Limited English Proficient (LEP), and 4.5% (*n*=445) were students with disciplinary placements in the alternative center.

Dropout rates for the school district are similar to the overall rates in the state of Texas. The Texas Education Agency (TEA) calculates the annual dropout rate by dividing the number of students who drop out during a single school year by the total number of students enrolled the same year. The latest report by TEA to the Texas legislature indicated that the overall dropout rate in the state for the 2006-2007 school year was 0.4% for students in grades 7-8 and 3.9% for students in grades 9-12, a 0.2% increase from 2005-2006. In this school district, the dropout rate ranged from 0.9% to 1% in the two middle schools, and was 2.8% at the high school. The alternative learning center had a dropout rate of 4.9%.

Participants: Recruitment and Sampling

The sampling of the 27 participating mothers was conducted in a manner consistent with what Bogdan and Biklen (2003) consider *purposeful sampling.* In this approach, the researcher chooses "participating subjects to include because they are believed to facilitate the expansion of the developing theory," (p.65). For this study, this included Mexican American mothers of adolescents from the district in three different groups: a) students in mainstream education, b) students attending the alternative center

who were placed there for behavioral problems in school, and c) students receiving counseling services through the district due to their internalizing problems (e.g., depression; anxiety). The reason for these groupings was to ensure that participants presented a range of experiences with adolescent problems, ranging from no significant problems, to behavioral and emotional problems.

Participants were drawn from three different pools for the three different groups. For the first group, mothers with adolescents in mainstream education, participants were drawn from a list of all students identified as "Hispanic" in grades 6 through 12 that was provided by the school district. Because the term Hispanic does not guarantee that participants were of Mexican descent, in all instances of contact, the participant was first asked whether they were of Mexican descent. All participants who were contacted based on their self-identified status as Hispanic confirmed that they considered themselves of Mexican descent.

Potential participants in the first group were randomly selected from the list of all eligible participants (n=2,757) and were contacted via phone by the investigator. Out of a total of 36 attempted contacts for invitation, 12 participants were not reachable via phone (due to inaccurate contact information or disconnected numbers) and were subsequently mailed a letter. No letters were returned expressing interest in the study. See Appendix A for the invitation letter that was mailed out to potential participants and Appendix B for the return letter indicating their interest in the study. Another 8 declined participating altogether, and 3 initially agreed to the interview but did not show at the time of the appointment, and did not reschedule. In the end, a total of 11 were successfully

interviewed. Of these 11 interviews, 8 were conducted in English, and 3 were conducted in Spanish. All the interviews in this groups, as well as the other two groups of participants, were conducted by the investigator.

For the second group, mothers were eligible if they had an adolescent child in the discipline alternative center, and if they identified as Mexican American when asked based about their Hispanic status. Out of the total 34 attempted contacts for invitation, 11 were not reachable via phone and were mailed a letter, none of which were returned; 14 declined participation, 2 did not show at the time of appointment and did not reschedule. A total of 7 were successfully interviewed. Of these 7 interviews, 3 were conducted in English, and 4 were conducted in Spanish.

The third group was composed of mothers whose children were receiving counseling services. In the district, there were a total of 28 students of Mexican American descent between the ages of 12 and 17 years receiving counseling services. Of these students, 7 were not eligible to participate in the study due to dual roles with the investigator, namely that the investigator was serving as their special education counselor at the time the study was being conducted. Furthermore, because of the fact that these students' privacy is protected under federal special education law, these participants could not be called directly by the investigator. For this reason, special education staff, namely the district's school psychologists or the students' counselors, were asked to invite participants on behalf of the investigator. Once a potential participant indicated she was interested in learning more about the study, their contact information was passed on by the child's psychologist or counselor to the investigator, who then made contact via

phone call. A total of 15 mothers agreed to be contacted, and of those 15, 2 did not answer phone calls, 3 declined participation, 1 did not show up to the scheduled appointment, and 9 agreed and were successfully interviewed. Of these 9 interviews, 6 were conducted in English and 3 were conducted in Spanish.

In the end, a total of 85 mothers of adolescents enrolled in the district were contacted via phone or mail. Of these 85, 25 declined, 6 did not show up at the scheduled time and place, and the other 23 were not reachable via phone and did not make contact with the investigator after a letter was mailed to them. As such, 27 mothers were interviewed. Of the 27 participants, 11 participants had adolescents in mainstream education services, 7 were participants with an adolescent who had been placed in the alternative center for behavioral problems, and 9 participants had an adolescent receiving special education counseling services through the school district. The demographic information for the 27 participants is included in Table 3.1.

Table 3.1 Participants' Demographic Information

Participant	Age	Lang.	Marital Status	Generation In U.S.	Religion	Occupation	#Adol/ Total	Group
Macrina	47	Eng.	Married	Unsure	Catholic	Teacher	2/3	Main.
Magdalena	34	Eng.	Married	4th	Catholic	Insurance adjuster	1/1	Main.
Maria	42	Eng.	Married	4th	Baptist	Homemaker	2/4	Main.
Maricela	42	Span.	Married	1st	Catholic	Hairdresser	2/3	Main.
Marina	36	Eng.	Married	3rd	Christian	Secretary	1/2	Main.
Marisol	38	Span.	Married	1st	Catholic	Childcare	2/2	Main.
Marta	37	Span.	Married	1st	Catholic	Housekeeper	2/5	Main.
Matilde	50	Eng.	Widow	2nd	Catholic	Secretary	1/1	Main.
Mayra	48	Eng.	Married	2nd	Catholic	Teaching assistant	1/3	Main.
Mercedes	52	Eng.	Married	5th	Baptist	Business owner	1/4	Main.
Monica	39	Eng.	Married	2nd	Christian	Youth minister	2/4	Main.
Laura	46	Span.	Divorced	1st	Catholic	Custodian	1/7	Couns.
Leticia	43	Eng.	Married	Unsure	Catholic	D.A.'s Clerk	2/3	Couns.
Lidia	47	Eng.	Married	3rd	Christian	Substitute teacher	1/2	Couns.
Linda	31	Eng.	Divorced	5th	Catholic	Medical Asst.	1/3	Couns.
Lolita	55	Eng.	Divorced	4th	Nondenom.	Disabled	1/4	Couns.
Lourdes	39	Span.	Divorced	1st	Catholic	Housekeeper	2/5	Couns.
Lucia	43	Eng.	Divorced	3rd	Catholic	Secretary	2/2	Couns.
Luisa	34	Eng.	Married	2nd	Catholic	Medical Assistant	2/3	Couns.
Lupita	43	Span.	Married	1st	Catholic	Early Childhood	1/2	Couns.
Sandra	36	Span.	Married	1st	Catholic	Elderly care	2/4	Alt.
Sara	37	Span.	Separated	1st	Catholic	Homemaker	2/7	Alt.
Selina	39	Span.	Married	1st	Catholic	Homemaker	3/5	Alt.
Silvia	46	Eng.	Married	3rd	Christian	Cashier	2/2	Alt.
Sofia	37	Span.	Married	1st	Catholic	Housekeeper	2/3	Alt.
Soledad	30	Eng.	Married	4th	None	Accountant	1/3	Alt.
Sonia	40	Span.	Married	1st	Jehovah's Witness	Homemaker	1/3	Alt.

As it can be seen in the table, the participants represent a range of backgrounds and demographic make-ups. The age of participating mothers ranged from 31 to 55 in the case of a participant who was raising her grandson. With regard to marital status, most of the participants were married (n=20), 5 were divorced, one was separated, and one was a widow. The number of children varied from 1 to 7, and the number of adolescents between the ages of 12 and 17 years in the households varied from 1 to 3. Participants' occupations were varied, ranging from homemakers and housekeepers, to more professional occupations, such as a school teacher and a medical assistant, to a business owner. With regard to religious affiliation, the majority of participants (n=18) described themselves as Catholic, four considered themselves Christian, two Baptist, one Jehovah's Witness, one nondenominational Christian, and one who did not consider herself to have any religious affiliation.

There was a range in the length the family had been in the U.S., including recent immigrants who had only been in the country a total of 4 years, and were therefore considered 1st generation, to people who considered themselves 5th generation. As a result of some of the participants being immigrants, the language spoken varied from Spanish-speaking only, to English-speaking only, with many considering themselves bilingual to varying degrees.

In addition to the mothers interviewed, who were the focus of the research, interviews were conducted with two *curanderos* and with one Catholic priest. Based on the information that emerged from the interviews with the mothers, it was deemed useful to gather information from these sources in order to triangulate information for the

model. Furthermore, it was of interest to determine how close the participating mother's perceptions were regarding these two resources in the community to what *curanderos* and priests believed they had to offer. Also, given that mothers frequently cited their spiritual and religious faith, particularly their Catholic faith, as a reason for not seeking out the help of *curanderos*, it became of interest to the researcher to obtain first hand information on the Church's position on the use of traditional folk healers, such as *curanderos*.

The first step in finding a *curandero* was to ask participating mothers whether they knew any *curandero/as* in the community. Although some reported they knew of someone who might know of a *curandero*, ultimately none was able to provide a useful lead or contact. The next step was to ask community members who were employed by the school district. This, again, did not yield any viable results. The next step involved driving around the community looking for signs advertising services. This did not yield any leads, as there were no *curanderos* in the area who appeared to advertise or have business signs up.

A large local flea market was also visited in hopes of finding information regarding where to find a *curandero*. Within the flea market there were three *hierberias*, or stands where natural herbs were sold. The people attending to the stands, however, all reported that they did not consider themselves *hierberos* or *curanderos*. Furthermore, none of them knew of where a *curandero* might be found. In fact, all three people asked indicated that they had not heard of any *curanderos* in the community. Within the flea market there was also a stand that sold religious artifacts, such as crucifixes and paintings of saints, as well as candles, incense, and amulets. They, too, were unable to indicate

where a *curandero* might be found, and reported they did not know of any in the community.

The final step in finding a *curandero* involved extensive internet searches. While there were no advertisements or websites that turned up in the searches, an article in a local newspaper dated 1993 was found in which a local *curandero* and his Mexican imports shop were featured. Although a dated article, further searches indicated the Mexican imports shop was still in business, and a phone call was placed. The owner of the shop, who considers himself a *curandero*, answered the phone and agreed to an interview in person. This interview was conducted in his office, and lasted approximately two and a half hours. In addition, the *curandero* gave a tour of his shop and the items sold, which included candles, herbs, amulets, religious statues, special waters, and other items.

The interview with the Catholic priest was arranged by placing a call to the Catholic Diocese in the area, and making arrangements with the Diocese's Director of Media and Communication. The diocese required that all people seeking to obtain any official statements from clergy be cleared by this department. Once permission was obtained, a request was made to interview a priest who specifically worked in the parishes that serve the school districts. Arrangements were made to interview him in his parish office, and the interview lasted approximately 2 hours.

Data Collection

The primary method for collecting data was semi-structured interviews. Semi-structured interviews are typically used in grounded theory research to learn about

participants' thoughts and beliefs (Bogdan & Biklen, 2003). These less structured interviews are used to investigate individual's perceptions, with the purpose of understanding their beliefs in their own words. The interviews were conducted by the principal investigator, and were conducted in English or Spanish, depending on the participants' language of preference. Of the 27 interviews conducted, 17 were primarily in English and 10 were primarily in Spanish.

The interviews were scheduled around the participants' availability, and were conducted either in the participants' home (n=10) or in one of the schools (n=17). Interviews with each participant were audiotaped and lasted approximately 60 minutes, with the longest interview lasting approximately 120 minutes. Upon completion of the interviews, the primary investigator transcribed all audio tapes. When the interview was conducted in Spanish, the investigator transcribed and translated all interviews such that in the end all transcripts were in English.

Interview

The semi-structured interview was based on a guide that consisted of the various topics that were of interest in this study. First, a set of demographic descriptors were gathered, including: mother's age; information on parental education; work; language spoken by mother and child; length of time the family has been in the U.S. A brief history of the family was also gathered, which included information on extended family and their use of family in times of need. The next topic tapped into the participant's religious or spiritual beliefs, their religious involvement, and their use of a church or the spiritual in times of distress. The interview then moved on to participant's perception of adolescent

problems in general, their own child's in particular, and their history of help-seeking behaviors for their child. In the event that they had not encountered problems with their adolescent, they were asked to speculate on what they would consider using should the need arise. In addition, participants were asked questions regarding their own experiences with problems, and their help-seeking behaviors for themselves. The participants were also asked questions regarding their thoughts on services available to them for addressing their children's problems, including school personnel (e.g., counselors; nurses; teachers), and other professionals, including doctors and psychologist. Finally, participants were asked about their knowledge and/or use of alternative resources for their child's mental health problems, including traditional Mexican folk healers (e.g., *curanderos; hierberos*), religious figures, and family. The interview map used in this research can be found in Appendix C.

Given that participants were asked questions regarding a wide variety of problems adolescents may face and whether they had any experiences with those problems, at the conclusion of the interviews, participants were asked whether they felt they needed any guidance in finding resources within the community. Participants were informed that if they needed a list of resources, such a list was available to them. This list included a list of different agencies in the community and their contact information. Information on agencies to help in crisis intervention, parenting, health, and sexual health, such as the local Mental Health/Mental Retardation center, Psychiatric Emergency Services, SafePlace, and Planned Parenthood, were included. The complete list of resources can be

seen in Appendix D. Of the 27 participants, only two requested and received a copy of the list that was offered to them.

Given that the information sought through the interviews was very personal and potentially sensitive in nature, one might question the likelihood that participants would share such information with a researcher with whom they have no preexisting relationship. Furthermore, during the time informed consent was obtained, it was explained to the participants that there was risk associated with participating, including feeling uncomfortable talking about certain topics, and that it was their right to share only what they felt comfortable sharing. Despite the risk, participants were encouraged to be honest with the researcher. As will be seen in the presentation of the results, it is clear these concerns were not supported. The participants shared some extremely sensitive and personal information, and many participants even cried as a result of sharing some of the information with the researcher. In fact, when the researcher expressed concern that the interview was difficult for one participant, she replied with a laugh, "Hey, you said there were risks," indicating she did not mind sharing and crying. In fact, that participant, along with numerous others, expressed they enjoyed talking to someone, even saying they had expressed things to the researcher they had never told anyone before.

Furthermore, it is likely that people who are reluctant to self-disclose about the problems they have faced with their adolescents, and the very personal choices they made or would make in dealing with those problems, selected themselves out of the study, as in the case of those who refused to participate, or those who did not show up for the scheduled interview time.

The interview with the *curandero* involved asking open-ended questions regarding a number of topics related to being a healer, including: where and how they learned to heal; what the source of their healing powers, if any, is; what types of cures they perform and for what ailments; what age ranges they work with; what problems specific to adolescence they work with; what connection there is between their healing and the spiritual world.

The priest's interview involved asking questions regarding services the church provides to families facing problems, particularly with their adolescents. The priest was also asked to summarize the Church's position on the use of folk healers, such as *curanderos*. A summary of the interviews with the *curandero* and priest can be found in Appendix E and will be discussed further in Chapter 5.

Data Analysis

Data analysis involves constructing meaning from the interviews (Staruss & Corbin, 1998). After the interviews were transcribed, the goal was to reveal relevant themes and concepts that could be grouped into similar categories, and ultimately develop connections among categories to move into more encompassing themes. This is accomplished through a sequential process, with preliminary data analysis informing future data collection (Jacob, 1987). After initial categories were identified, additional interview questions were developed in order to further develop the understanding and verification of the initial categories. In the end, saturation was reached when certain categories emerged consistently, with less and less new information emerging during the interviews.

As data collection progressed, categories and concepts began to emerge through a process known as open coding. Axial and selective coding were later used in organizing the relationships that developed among the resulting categories. While these three types of coding are discussed separately, often they occurred simultaneously.

Open Coding

The initial stage of data analysis in grounded theory is open coding, which yields categories that represent the phenomena in the data (Strauss & Corbin, 1998). There are three steps involved in the process of open coding. First, one must label the phenomenon, which consists of identifying phrases or sentences that depict each of these phenomena and then providing a name to represent each of these phenomena. The next step involves organizing each of these labels in a way that similar concepts can be grouped together into more abstract categories. These categories are labeled in a way that represents the more generalized and abstract nature of the content of the subcategories that were represented in each category. The phenomena that were labeled reflect the participants' perceptions of adolescent health and problems, the family's roles in the prevention of problems, and their perceptions of resources in helping with adolescent problems (including family, religious figures, mainstream resources, schools, and alternatives such as curanderos or hierberos). For a list of categories from open coding, see Appendix F.

Axial Coding

Upon completion of open coding, the categories that emerged were then applied to axial coding. This purpose of this step is to develop connections and relationships among the categories that emerged in prior coding (Strauss & Corbin, 1998). In this step,

a coding paradigm is applied that involves a number of elements, including identifying causal conditions, context, intervening conditions, action/interaction strategies, and consequences.

Causal conditions are the events that lead up to the phenomena. It is a set of causes and their properties. These events are generally signaled by words such as "when," "since," "because" or "due to." In reality, a phenomenon is not produced as a result of a single causal condition, and therefore it is important to describe the specific properties of causal conditions. Context refers to the set of properties, or background variables, along with the specific dimensions, of the phenomena. Similar to context, intervening conditions are those variables that define the broader context, like mediating variables, which act to facilitate or inhibit the presentation of the phenomena. Action/interaction strategies refer to the purposeful activities that an individual engages in to respond to a specific situation or phenomenon. Finally, consequences refer to the outcomes of the action strategies, intended or unintended, that happen to individuals. The relationships that emerge among the categories, based on each participant's responses, are then applied to new cases as data continues to be collected.

Several approaches were taken to identify the relationships between the categories that emerged in the data. First, conceptual hierarchies such as those seen in Appendix F were developed. In addition, for each participant, the connections that emerged between her beliefs about any particular resource available to her for her adolescent and her likelihood of seeking that resource out were established. This process occurred as a direct

result of comments made by participants during the interview or as a result of discovering such connections as each participant's transcript was analyzed for those patterns.

Selective Coding

Selective coding was the final step in organizing the data. It involves choosing a core category, and relating all other categories to that category. The result of this procedure is a grounded theory that integrates the categories that have emerged in the data (Staruss & Corbin, 1998). The idea is to develop a single *storyline*, a summary that represents the most salient category in the data. This storyline is developed by identifying the properties and dimensions of the core category. Other categories can then be related to it through the paradigm just described. During the selective coding process, there is also the identification of patterns among the properties of the core phenomenon that lead to varying outcomes. Within the model, intervening conditions are particularly important, as they help determine why one individual has one outcome, and another has a different outcome.

As the grounded theory continues to be developed, the researcher uses direct statements from the participants to illustrate the categories and their relationships. Individual cases are then compared to the model to see if they conform. If some cases do not fit the developing model or storyline, it is reorganized or detailed further so that it captures all information from the participants.

Controls for Researcher Bias

Due to the nature of qualitative research, it is important to consider the role the researcher plays in data collection and analysis. Due to the professional and personal

experiences the researcher brings into the research process, it is important to take some controls in order to assure the trustworthiness of the findings. Trustworthiness refers to accounting for the credibility, transferability, dependability and confirmability of the data collection and analysis (Guba & Lincoln, 1994).

Credibility

Credibility refers to a researcher's ability to analyze the data in a way that matches the meaning intended by the participants (Guba, 1981). In order to ensure participants' voices are heard, Fontana and Frey (1994) have suggested gaining an understanding of the participants' language and to consider the complexities of the subject matter. Unstructured or semi-structured interviews naturally lend themselves to this method. I ensured participants' meaning emerged by engaging in active listening, as well as frequent paraphrasing to convey meaning back to the participants for verification.

In addition, 2 participants were asked to meet with the researcher a second time for a follow-up meeting. The purpose of this meeting was to give the investigator the opportunity to share her interpretation of the participants' responses in the original interview with the participants themselves. This process is called "member checks" by Guba (1981), and is considered an important step in establishing credibility. During the follow-up interview, participants were first asked probing questions like the ones asked in the initial interview, particularly regarding the steps they had taken or would take when faced with problems with their adolescent, as well as their thoughts on the various resources available to them. Second, they were asked about the connections the researcher made between their thoughts about resources available to them and their

likelihood of seeking them out in the future. After the interview, the participants' responses during the follow-up meeting were compared with the investigator's interpretations made from the content of the initial interviews.

What resulted in this exercise was the verification that the investigator's interpretations were consistent with the participants' originally intended meaning. Namely, when the participants were asked about some of the conclusions and inferences made by the investigator, they generally agreed, indicating credibility appeared to have been established.

In addition, an interview was conducted with a participant as a way of testing the developed model. This consisted of interviewing a person with the final interview procedure, summarizing it, and then comparing it to the developed model. Once the interview was transcribed and analyzed, it was conceptualized and the model was applied to the conceptualization to determine whether the connections that had been established, particularly between the participant's perceptions and relationships with the various types of resources and their help-seeking behavior, held true for the test case. Ultimately, the goal was to predict various components of the new participant's help-seeking behaviors based on their descriptions of their perceptions of various resources. For example, the model would predict that an individual who had a very strong religious or spiritual faith would be likely to seek out the help of spiritual leaders in the form of prayer. The results indicated that it was possible to predict most of the components of the individuals help-seeking behaviors based on the model, supporting the credibility of the model that emerged from the original data set.

A final step in ensuring the credibility of the analyses was the use of peer debriefing. Guba (1981) describes the process of peer debriefing as a collaboration with colleagues that allows the researcher to explore and critique the developing model. Throughout the process of collecting and analyzing data, the researcher met regularly with one dissertation committee member knowledgeable in grounded theory methodology. The meetings included review of transcripts and the categories that emerged, feedback on adjusting the interview, and detailed feedback regarding the emerging model.

Transferability

The concept of transferability in qualitative research is analogous to the concept of external validity. As such the concept is intended to ensure that the results of inquiry are applicable to other individuals- that is, they have generalizability. Two ways in which this is accomplished is the theoretical sampling procedures employed and by collecting detailed information. Theoretical sampling is the process by which participants are chosen in order to represent a variety of experiences and thus provide a range of information. In this study, sampling consisted of randomly selecting participants from a list of all students enrolled in middle and high schools in the school district. These represent a group of parents whose adolescents are part of mainstream education, who likely have few instances of behavioral referrals, as evidenced, but not guaranteed, by not being in the alternative center, and who likely do not have emotional difficulties, as evidenced by the fact that they do not receive special education counseling services. The second group consists of participants whose adolescent had received a disciplinary

placement in the alternative center, and the third group consists of participants whose adolescent child has a history of receiving special education counseling services. The reason for these groupings was to ensure that participants presented with a range of experiences with adolescent problems, ranging from no significant problems, to behavioral and emotional problems. Interviewing individuals with a range of experiences and conceptualizations allows the findings to be utilized in contexts that extend beyond the data collection sample.

Furthermore, the applicability of findings is facilitated when extensive data is gathered for each individual. The collection of information via detailed interviewing allowed for the gathering of "thick descriptions" (Guba, 1981). In this study, detailed information was gathered from each individual, including demographic information, information regarding family relationships, as well as beliefs and concepts of outside entities, such as schools, professional healthcare providers, and traditional folk healers. This detailed information was used to develop individual profiles, which in turn can be used to determine if characteristics of non-participants are similar enough to the characteristics of the participants to allow for the application of the model developed. As a result of the developed detailed profiles, it should be possible to apply the findings from this study to a range of individuals with a variety of experiences related to help-seeking behaviors.

Dependability

The ability to allow for the replication of findings is an important concern in any research, including qualitative research. To this end, the detailed collection of data, as

well as detailed analysis notes, were carried out throughout the study. This created what Guba (1981) refers to as an "audit trail." Furthermore, regular meetings with a dissertation committee member took place to ensure that the data collection and analysis were being carried out within the procedures delineated by grounded theory.

Confirmability

The idea of confirmability is concerned with whether the data and analyses are a product of the inquiry, rather than researcher biases (Erlandson, Harris, Skipper, & Allen, 1993). First, in order to ensure the confirmability of the data, the researcher made every effort to use non-leading questions and to use the participants' own words when asking questions or paraphrasing their statements. Furthermore, when reporting findings as will be seen in Chapters 4 and 5, the researcher uses participant's voices. This is accomplished through direct quotes from the interviews that support the model.

Furthermore, as part of the data analysis process, a portion of the transcripts were reviewed by a committee member familiar with grounded theory methodology. This committee member reviewed uncoded transcripts and compared them to the developing categories and subcategories developed by the researchers to determine fit.

A final procedure to ensure the confirmability of the data involves considering researcher biases. Personal experiences and thoughts of the researcher can be a valuable tool in a qualitative study, but the researcher must be aware of her assumptions and biases.

Researcher

As the researcher, it is important to examine how my background, values, and biases may influence interpretation of the data. There are a number of areas that need to be considered in regard to my experiences and how they pertain to this study. These include information pertaining to my background, my experiences within my family, my spiritual and religious background, my experiences with traditional folk healing, my school experiences, my experiences with psychotherapy, and my relationship with the school district.

I am a 31-year-old woman in the School Psychology program at the University of Texas at Austin. I am of Mexican descent with a complicated background, being 2nd generation Mexican American, but with roots on my mother's side that would make me 4th generation. I come from a large, but close-knit family, being the youngest of eleven children. Today, communication with my siblings is very open, and we "count on" each other in times of need.

I grew up in a devoutly Catholic household in which daily prayers were a habit, and Sunday trips to church were routine. Even when I reached the age in which it was my choice whether to attend church regularly, specifically during high school and college, I chose to attend church regularly. I even developed a very close relationship with my parish's priest when I was 17, which continued well into adulthood. In this relationship, I looked to him for guidance in making important decisions, and as a source of comfort during difficult times. Today, I find myself a Catholic by name, but not by practice. I

have come to disagree with many of the teachings of the Catholic Church, and now only attend services during the holidays, particularly Easter.

With regard to my experiences with traditional folk healing methods such as *curanderismo*, I was brought up believing that *curanderos* were not a suitable option when seeking out help for problems because they operated in a manner that was contrary to our religious background. This was not a belief that was specifically conveyed by the Catholic Church, but rather by my parents. In particular, my mother would point out an uncle, whom she believed was on the "wrong" path for being a devout follower of Don Pedrito Jaramillo, a *curandero* who practiced in south Texas in the late 1800's, and whom many believe continues to heal even today through his spirit in a shrine devoted to him.

With regard to my experiences within schools, my educational experience was a very positive one. Having grown up in a mostly bilingual household, my first years in school were in bilingual education, just like the vast majority of the other students in my district. I had generally positive experiences with teachers, and classes, and early on was placed in the gifted and talented track. This was a trend that continued through high school, and ultimately led to my graduating as valedictorian of my graduating class. I attribute part of my success to the support of teachers, counselors and administrators, as well as the value my family placed on education.

My relationship to the school district dates back 4 years to when I was a second year student in the School Psychology program. At that time, I was enrolled in a practicum as part of my program that placed me in that school district. As part of this

practicum, I worked with junior high and high school students in psychoeducational and socio-emotional assessment, as well as cognitive behavioral therapy (CBT). At that time, I developed a positive relationship with one of the supervising school psychologists. Two years later, I again was placed in that school district for another practicum, this time providing counseling services with an interpersonal approach. This was during the time-frame that I obtained permission from the district to collect my data there. Finally, last fall, upon completion of my internship in psychology and after having obtained my master's level certification as a Licensed Specialist in School Psychology (LSSP), I was hired full time by the district's Psychological Services Department, within the department of Special Education.

During this time, my role in the district has consisted of a variety of roles related to being a school psychologist. Primarily, I provide counseling services to 25 special education students ranging from 2nd grade to 12th grade on an individual basis, as well as through group counseling. I also test students who need psychoeducational and socio-emotional assessment as part of the special education services. Furthermore, I develop programming for students exhibiting behavioral difficulties via functional behavioral assessments (FBAs) and the development of behavioral intervention plans (BIPs). I also provide consultation services to teachers throughout the district.

The dual role I serve in the district merits being addressed. At the start of my dissertation data collection, I had contact with very few students, and it was relatively easy to maintain my roles clear and separate. Upon becoming an employee of the district, however, it became important to clearly delineate my two roles within the district. First, it

was imperative to ensure that none of the parents of students to whom I provided direct psychological services were included in the study. Second, I had to ensure that my two roles did not overlap by only conducting research interviews outside of school hours. District space, however, was used for interviewing as it was permitted by the district even before my employment.

CHAPTER 4: Descriptive Summaries

Before exploring the findings, which are presented in chapter 5, it is important to provide a picture of the participants in this study. It is their stories that are the foundation for the model that has emerged from this study. These descriptive summaries are provided with the intention of providing a "snapshot" of selected participants in order to gain insight into the context of their experience and how that shaped the opinions and attitudes they expressed in the interviews. In this chapter, the profiles of 6 participants are provided, 2 from each of the three groups as described previously, namely: a) mothers with adolescents in mainstream education, b) mothers of adolescents with behavioral problems who have been placed at the alternative center, and c) mothers of adolescents with emotional problems who are receiving counseling services through Special Education services within the district. These profiles include background information, their experiences with adolescent problems, their thoughts on resources available to them, and their help-seeking behaviors, whether actual or predicted. These 6 participants were selected because they exemplify various aspects of the model. Brief profiles for the other 21 participants can be found in Appendix G.

Maria

Maria is a 42 year-old "stay at home" mother with a 10th grade education. She has been married 10 years, although she reported she and her husband had been a couple for 17 years. Maria considers herself a 4th-generation Mexican American. Her primary language is English, but she knows some Spanish. Maria has 3 children, ages 26, 22, and

17 years from previous relationships, and has no children with her current husband. Maria is also raising 4 of her grandchildren who had been removed from their biological parents by Child Protective Services (CPS).

Maria has one sister and one brother. Her mother has passed away, but her father is still living. She considers herself to have a close relationship with his father, but not her sisters:

> My sister K… I really don't know if she doesn't like me or what. I'm the only one married. And I guess I have stability. And we have conflicts. I moved to Maryland to be with her. We used to be close when we were little… And since then we haven't been that close…. And I'm not happy about that… But I get along with her. She says her hi's and bye's. And we're pleasant and that's about it.

As a result of not being close to her sister, Maria has come to believe she cannot count on her in times of need. Instead, when Maria has a problem she counts on two people:

> My husband. When it comes down to it, it's my husband. He knows the deepest, darkest. He knows when I'm down. Daddy tries, like when mamma died, and I couldn't handle it. I was a nervous wreck… So I called my dad and I said, "I can't handle it. I think I'm just going to have a nervous break down." He said, "Eat some ice cream, Maria." I was like ok. I got it out of the refrigerator. But it was difficult… But daddy tires.

Maria reported that she grew up in a household that was Catholic, but that she currently considers herself Baptist, having been baptized in that faith as an adult. Maria

described herself as a woman of faith who believes in God's power to touch and change lives in very positive ways. In her case, Maria believes God brought her husband into her life to make her life better:

> I think it starts with the people in the church that we see God, and God is guiding them. And I always tell my friends this story- God doesn't come down in this roaring thunder, he brings angels in front of you. And I've had many angels in my path. I've had a lot. Things happen. And I remember when god spoke to me and said "hey, you have to calm down. Today is the day." … I changed that day. I was no longer the ugly woman. I was no longer the ugly duckling. The bad person. And all of a sudden I was happy and I knew how to love and I knew how to care. It was instantaneous. And I don't know if it was God replying, "Here you go."

Maria also sees God and the church as a resource in times of need, specifically through the power of prayer, if she felt she "couldn't take any more." Maria expressed the belief that religious figures, such as priests, could be particularly helpful because "they know how to pray right. They know how to ask God to help us."

Maria described her 17-year-old son as a child who had not given her many problems. Her son had no history of significant behavioral or emotional problems, and was actually about to become her first son to graduate from high school. Maria, however, had experiences with her older sons when they were teenagers that included academic difficulties and a history of ADHD, which she believed contributed to their dropping out of high school. Maria, however, also blamed herself for a lot of her older sons' emotional

problems, citing choices she made in her life that led to turmoil. Furthermore, the eldest children's father was imprisoned during their childhood, and she believes that also affected them.

As a response to some of the problems she experienced with her sons, Maria found herself seeking help from her parents, and at one point she even asked that her parents take in her eldest son at age 17 years because she could not manage his behaviors, which included fighting, truancy, and problems with law enforcement. At the same time, Maria sought family counseling to help with the problems she was facing with her son:

> And we get into this counseling, and one by one I was being picked. "Well, mom, to say the truth, it's because of you. You get angry and you get mad." And my husband said, "You know, Maria, that's true." And little by little everyone was picking at me. And I went back saying, "me? I'm the problem? We're here for J and I'm the problem." And I remember just being very upset. But I had to take that for what it was. [My son] blamed me because I made the initial [move], we're going to go for you. And my husband was mad because I didn't know how to let go when [my son] and I would get into an argument I would push the issue instead of letting it settle. And I didn't know how to do that. And [my other son] was blaming me because he saw that I was too pushy. I remember going into counseling and I did not like it.

Maria described that although her experience with counseling was a difficult one for her personally, it was a helpful and she eventually realized that "this guy, this counselor.

Psychiatrist. He's right about everything that is going on here. He would say, 'it seems that you are the bigger issue.'"

Maria was also a woman who was aware of the different resources available to adolescents and was open to things such as turning to her father, asking the church for prayer, turning to the school for help, and would consider consulting with her medical doctor. Maria, however, was not willing to consider the use of *curanderos* if a problem should arise with her son, saying "I'm totally, totally against it" because she considered it to be *brujeria*, or witchcraft.

Maricela

Maricela is a 42-year-old hairdresser who works full time. She has been with her partner for 15 years, whom she calls her husband despite not being legally married. He, also, is a Mexican immigrant. Maricela has two children of her own, a 14-year-old daughter, and an 11-year-old son, and in the last year she and her husband adopted his 17-year-old and 12-year-old sons from previous relationships. Maricela is an immigrant from Mexico City who has been in the U.S. for 17 years. Maricela's dominant language is Spanish, and she reported being limited in her English proficiency, therefore the interview was conducted in Spanish.

Maricela moved to the U.S. alone and her parents and siblings are still in Mexico City. She reported that see each other every two years when she travels to see them. She reported that as a result of the distance she was not able to turn to her family much for help, and instead turns to her husband when she is faced with a problem.

Maricela grew up in a Catholic household, and continues to consider herself Catholic, although she attends a non-denominational church with her husband who considers himself a Christian. Maricela summarized her spiritual and religious beliefs and practices as follows:

> I am a believer, Lucy, Catholic. I'm not saying I'm a very devoted Catholic. I don't do everything. But lately we've been accompanying-- my husband is Christian. He converted about 2 years ago. He joined this religion and for that reason I have joined him. And it pleases us. It's nice. They don't criticize what I believe in. They have a lot of respect up until now. I don't know later. But I am a believer. I believe in God.

Maricela expressed the belief that the church she and her family attend "can definitely help." She stated that attending church regularly was a positive thing because:

> When you are close to God, well he lights the way for you. He opens doors for you, the roads to follow. Whatever God wants for us are only good things. And one way or another I think that by getting closer to him he can help you reflect in different ways. And I believe in miracles. I believe in miracles. And they definitely change us. When he touches your heart, he opens you and that makes you a better person.

Maricela reported that her 17-year-old step-son, who has been living with the family for the last year, has had some adjustment problems as a result of leaving Mexico and moving in with his new family. His incorporation into the family had also affected Maricela's 14-year-old daughter who had to adjust to having a new sibling in the home

and no longer being the oldest child. Maricela reported that before her step-brother moved in, her daughter had not experienced significant emotional, behavioral, or school problems. As a result of the adjustment problems that arose as a result of the change in family composition, Maricela and her husband have encouraged their children to get involved in activities, and have made an effort to do things together as a family:

> Well, we always try to get them involved, encourage an activity. Let's do something together. If we want to go out and the boy says he wants to stay because whatever, he doesn't want to go out with us, maybe we aren't doing the right thing, but we take him with us anyway. "No, come on, let's go. Let's watch [your sister's] match." And he wants to go even less. But we make him. We say, "let's go. Let's go to McDonald's." Try to persuade him so that we can all be together and not leave him behind all sad.

With regard to other resources available to her in helping with adolescent problems, Maricela reported:

> Well, all of our problems we have solved amongst my husband and me. That's my first choice. Beyond that, I don't know. Look for a counselor. But at first it would just be us with the family, definitely.
>
> Investigator: And when you say counselor, do you mean at the school?
>
> Maricela: It depends on the problem. If it's related to school, well, yes. If the problem is greater. Honestly, I don't have an idea of someone in particular to seek out. But I would.

Investigator: Would you feel comfortable talking with a physician?

Maricela: Of course.

Investigator: And do you think that maybe you would feel comfortable consulting with someone in your church?

Maricela: Yes, also.

Investigator: We had talked about ways that church helps. If you had to go talk to someone at church, in what ways do you think it would help?

Maricela: Now that I've participated with my husband at his church, I do believe in miracles. I would talk to someone. Possibly one of the people with the most knowledge, I mean the pastor. And in that church they believe in prayer, Lucy. And I definitely believe in miracles. And I would seek them… But that's what I'd do. Maybe I would look for someone with understanding, like a psychiatrist. Why not? A doctor.

As it can be seen, Maricela is a person who would first try to solve problems with her husband. As mentioned previously, because of the distance between her and her family, she expressed she would not be able to count on them. Maricela, however, was open to seeking help from the school, as well as from doctors and other professionals. She also expressed she would be willing to seek out a pastor from her church. Maricela, however, reported she would not seek out the help of traditional folk-healers, such as *curanderos*, stating, "I definitely don't believe much in *curanderos*. I believe in doctors."

Sara

Sara is a 37-year-old mother of three sons, ages 14, 13, and 11 years, and four daughters, ages 8, 4, 1, and 3 months. The first five children are from her first marriage, and her youngest two are from her current relationship. Sara is a Mexican immigrant who moved to the U.S. 17 years ago. She has a 6th grade education, and is currently a homemaker.

Sara has five sisters, and is particularly close to one of them, describing her as, "the one I can talk to." She also reported she considers herself to have a close relationship with her mother, but that she does not much turn to her in times of need, "because she is older and I don't want to worry her."

Sara reported a significant history of domestic violence with her former husband. As a result of the domestic violence she and her family experienced, there were times she had to seek help from a local domestic violence shelter, SafePlace, and that at times she sought the help of her children's school:

> But in the beginning it was difficult because everything was really ugly and here [at school] there were problems with my son, the eldest because he misbehaved or did things. But here it helped me a lot because there were the counselors and Safe Place has also really helped. And the principals have been good because they have helped me. That is, they call me or tell me the complaints against my son… And it's helped us a lot too, because the therapist from SafePlace would come and talk to him here and over there too. And from there in SafePlace another man would come too to talk to all other kids, too, I think with problems. And then this year they created a program to give them work and my son submitted his application

and they took him. And they talk to them about violence and he was participating like in a theater group. And doing things related to violence, I think.

Sara believed that as a result of what the children had witnessed she and her children experienced a number of emotional problems. For her children, some of the emotional difficulties manifested as behavioral problems. She described them as becoming "a little rebellious," and as a result, her older boys, specifically the 14- and 13-year-olds had been getting in trouble at school, and therefore were placed in the alternative center. Sara, however, perceived the school as helping her children, rather than punishing them, because as a result of the problems, the children had had access to counselors, and had been talked to by the principal.

Sara reported she also turned to the Catholic Church when she and her children were going through the crisis with her former husband. She found by going to church she felt a sense of peace, as well as sense that she was not alone:

Sara: Yes, I like to go to church, too. That helped me a lot, too, when the crisis was at its worst. In the beginning it was really ugly. And so I was going to church, to retreats.

Investigator: Oh, yeah?

Sara: That really helped us out.

Investigator: And how do you think it was that these things helped? In what sense?

Sara: Well, to feel better. More tranquil. More peace. More comfortable. And I still keep going, but things have gotten a bit better. And well, we have faith, and we know God has never left us. And sometimes we still go.

Furthermore, Sara believed there is a clear role that religious figures can play in helping mothers out when having problems with their adolescents, "because they listen on one. Like priests listen to one. And they say, 'God is going to help and we'll pray for you.' And one feels like they've got someone. And more faith."

It was that same faith in God is that eventually led her to believe that *curanderos* are not an option for her and the problems her family has had or could face:

Sara: No, I don't believe in that. I think they are the same as us. And all they do is trick people to get money out of them. Because before I really started going to church I used to believe in that. But now that I've been going more to church I think that's all pure lies. It's not true. It's people who are just trying to trick people.

Investigator: Did you ever go see someone?

Sara: Yes, once because supposedly they were very good, and so on and so forth. And believing. And when I started going to church I heard that that was not good. And that it's just to take one's money. And that one shouldn't believe in those things because it's just God.

Sara then proceeded to share that in that instance, she had sought the help of a *curandero* when she discovered her husband was cheating on her. Sara, however, is now a person

who, despite having believed in the past, finds that her belief system has changed as a result of the message she felt the church sends on the use of *curanderos.*

Today, Sara considers herself a woman who knows how to find help when she needs it, whether from the school, or from outside agencies that provide counseling services, such as SafePlace. Sara also feels that she has her current boyfriend and sister to count on. The church has also been a source of help, and she would consider speaking to a priest or a nun if she needed to. Sara, however, would no longer consider the use of a *curandero* for any problems with her adolescents, or anything else, and specifically credits the church with her change in opinion about them.

Selina

Selina is a 39-year-old homemaker with three daughters, ages 17, 16, and 10 years, and two sons, ages 13 and 4 years. She has been married for 18 years. Selina and her family are recent immigrants from Mexico, having only been in the U.S. for 4 years. Selina considers herself a Catholic who does not attend church regularly, but has her faith, saying she believes:

> Well, in what I have been taught. That one believes in God and in the Virgin and in the saints and for me it's a beautiful thing because when I go to church and I forget about whatever problem I have. I forget about everything bad in there. And the bad thing is that one does not go regularly. We don't have much participation.

Selina's 17-year-old and 16-year-old daughter had been in trouble in school for fighting and what the school considers gang affiliation, which can include wearing certain colors to, or for displaying certain symbols. As a result, Selina's daughters had

been placed in the alternative center. While Selina acknowledged that her daughters were involved in the fight, she denied that the girls were, in fact, affiliated with any gang. When this happened, Selina's approach was to give her daughters advice on interpersonal problems such as those that led to the fight:

> Yes, they got into a fight. My older one had told me that there was a girl who tells her things, and so on. And I told her to not mind her. And it had been going on for days, and the other one, the younger one, also told me they were calling her names. And I said, "Why are you talking to her?" And she said "my friend introduced me to her, but I did not like her at all." And some days went by and I think that girl was harassing her, harassing both (daughters). And she said the girl only said things to her when they were with friends, never when they were alone. And I told her to just let her say things. I told her it wouldn't hurt her for her to just say things. And the older one told me that the girl said to her, "do you want to fight?" And my older one said, "I don't want any problems."

In this example, Selina believed that her advice helped her daughter avoid further problems with girls in school, as evidenced by her daughter's response that was an attempt at diffusing the situation. During this situation, Selina stated she also consulted with husband and one of her sisters with whom she is very close.

Beyond giving her daughters advice and talking with her husband and sister, Selina reported she had called the school to help deal with the situation when her daughters were in trouble for getting into the fight:

Selina: And I called a counselor, or someone like that, Mr. C… I looked for him, because I saw his name in one of the booklets they send home. He was the only one I called. And I talked to him. But he told me that I needed to be the one to take her back to school when she was due back because she couldn't be there before. I said ok. And I talked to him. And he gave us some advice.

Investigator: And you felt comfortable talking to him?

Selina: Yes. Because he was able to help her see things better than we can. Like, "you shouldn't have done that." And she said, "Well, it didn't seem like a big deal to ask." And she felt that didn't need to happen to her. But that's what it's like here. It's the law. And one has to respect it.

To Selina, this counselor at the high school was someone she was able to turn to in order for her daughters to get advice from someone other than her. As it can be seen, she was attentive to the information that got sent home with her daughters and knew how to reach a person that could be helpful to her.

Although she had not felt the need yet to talk to her doctor or seek out the help of a psychologist, Selina expressed that if more serious problems were to arise she would feel comfortable seeking out the help of a psychologist. When asked if she would consider seeking out the help of someone in the church to address problems with her daughters, Selina had this to say:

Selina: Well, I would feel comfortable, but when it comes to family problems, I would say no. Like in the church I would say they are more for problems with

marriages, not family, because the children are more… well, a priest couldn't help. It wouldn't be very helpful. It would be good, but I think it's different.

Investigator: So you think it's more appropriate to-

Selina: To talk to other people about the family.

Investigator: And so you wouldn't talk to a priest about problems with the girls.

Selina: Well, anyone I feel comfortable with I would talk to about it, but I think that I would see more help in other more professional places than in the church.

Investigator: So you don't think they would have a way of helping you with something like that.

Selina: No.

With regard to the use of *curanderos* or *hierberos*, Selina reported that while she lived in Mexico, she had sought the help of a *curandero* for a health problem her husband was having, but that she "did not see an improvement and we decided not to go back." When asked if she would be willing to seek the help of a *curandero* for problems with her adolescent daughter, Selina responded by saying, "I think not, but no one should ever say, 'I'll never drink from that water.' But I think not."

Lolita

Lolita is 55-year-old woman who is raising her 12-year-old grandson. Lolita is the mother of three sons, all of whom are now adults and no longer living at home. Lolita was declared disabled in 2003, and therefore considers herself a stay-at-home mom. Lolita obtained a GED, and worked in different professions throughout her life, although she reported that her longest job had been as an apartment manager. Lolita considers

herself 4th generation Mexican American. Her primary language is English, although she grew up speaking both English and Spanish, and she considers herself to be proficient in Spanish. Lolita was divorced, remarried and then became a widow. Lolita currently has a boyfriend with whom she lives.

Lolita came to raise her grandson as a result of her son's imprisonment. After his imprisonment, her grandson was being cared for by his own mother, but there were extenuating circumstances that prompted Lolita to seek out custody of her grandson:

> [His mother] couldn't handle him. And she would bring him. And she wouldn't take care of him. So I would bring him in and take care of him. I fought for him. She was going to get married again, but she didn't have a place, she didn't have a job, and so I just wanted him. Because she was in a shelter. And I took it upon myself to seek out the paperwork to get him. So I got him. She tried to tell the cops I took him, but I have all the paperwork.

Lolita comes from a family of five, and she also had one half-brother. She described her life growing up as difficult, reporting that there was a lot of abuse:

> Lolita: (Crying) I don't have anyone like that who's close. Because in my life I would get beatings (crying). I would hide from beatings and run away.
>
> Investigator: Who would hit you?
>
> Lolita: My mom and my two oldest brothers (continues to cry). I had two cousins who could have vouched for that, but one already passed away. She's the only one who cared for me and would take me in. Her and her mom.

In addition to her early history, Lolita described that there were other problems that created more distance between her and her siblings:

> I used to go to my mom. And ask for help. Ask her for financial help. And since then, I mean she helped me with the rent, the light, with food. But I would work it back. I would do her laundry. I would do her house. But I had my half brother who accused me of stealing. They even had APS- Adult Protective Services- investigate. And they would do this underhanded. One time I went to give my mom her medication, and they had gotten my niece involved. My sister's daughter. She's got Alzheimer's so she won't remember. But they got my niece involved. And they had me investigated, but it was nothing. And the woman from ADS dismissed it, but they wouldn't take it! They went to the police!

As a result Lolita finds herself today in a situation where she cannot count on anyone in her family if she has a problem. Furthermore, when asked whether she had friends who she could count on, she tearfully stated, "I thought I did, but I don't," and proceeded to share other stories that explained why she felt she did not have any friends she could count on.

Lolita grew up with a Catholic mother, but was baptized in a Baptist church at the age of 7. Currently, however, Lolita considers herself to not "have a particular religion," although she regularly attends Catholic mass as well as a nondenominational church. Despite not having a particular religion she identifies with, she has a strong faith in God, particularly in providing what you need, regardless of your religious affiliation:

> I feel that God is for everybody. I feel like it's not going to be because you're Methodist or Pentecostal or something. It's not gonna be that that gets you inside. It's how you are. And I feel like God gives you what you need. Like when my husband died. He died by accident and I came back from Houston and I was able to get set up with an apartment and everything. And I always had what I needed. You always get what you need.

Furthermore, Lolita expressed she could count on the church for prayer, stating, "I call the church and ask them to pray. Like, 'I have this problem and I would like for you to pray.' I know I can do that."

Since becoming her grandson's legal guardian in 2006, Lolita has had to deal with a number of emotional and behavioral problems with him. At school, he has been identified as a student with an emotional disturbance and a learning disability. The school is providing him with counseling services, and has a behavioral intervention plan (BIP) for him to address problem behaviors that include classroom disruption and task refusal. As a result of the number of problems her grandson has had, Lolita has been proactive in seeking out additional help for him. When she first adopted him, she sought out the help of an agency called Lifeworks, which provides services for children and adolescents experiencing a variety of problems, as well as through the local Mental Health/Mental Retardation (MHMR) agency. In addition, Lolita sought help through a family therapy service provided by practicum students from The University of Texas through the school district.

As can be seen, Lolita is woman who is savvy and aware of the resources that available to her. Although she does not count on anyone in her family, she is comfortable seeking out help through her grandson's school, as well as other outside agencies that can help with a variety of emotional or behavioral problems. Lolita also feels she can count on God and on her church, particularly for prayer. Lolita, however, does not believe the use of a *curandero* would be very helpful to her in addressing the problems she has faced with her grandson, stating, "it's not good," and elaborating the reason she would not seek one out is because she does not believe them because of her perception that they deceive people.

Lourdes

Lourdes is a 40-year-old mother of five boys, ages 23, 21, 17, 16, and 9 years, all of whom still live at home. She is an illegal immigrant from Mexico who has been living in the U.S. for 15 years. Before moving to the U.S., she had obtained a middle school education in Mexico. Her primary language is Spanish, although she speaks and understands some English. She currently works as a housekeeper and a companion to the elderly. She is divorced, but currently has a boyfriend who lives with her and her children.

Lourdes grew up the oldest in a family of 10 children. Being the oldest, Lourdes finds herself being the person her family turns to, and as a result she does not feel she has anyone to help her, saying:

> My grandmother says that in that family, I am the head. Because not even my mom or my dad. Sometimes my brothers, when they have a problem, they come

to me. My sisters, when they have a problem they come to me. Maybe because I'm the oldest in the family. Or because I always have a word of consolation. Or they feel supported by me because if it's Christmas they don't do anything until I decide what happens. My grandma says I'm the one who cuts and distributes the cheese. But now I think that's all ending. Because sometimes I think it's too much. One day I called my sister-in-law and she gave me a bunch of complaints about my brother. And I asked what she wanted me to do if they were there in Mexico and I was here. And then I hang up and one of my brothers here calls me and asks me to talk to his wife because of blah, blah, blah. Ok. And there I'm calling people, and then another, and they're complaining about this and that and each other. And I think, who's going to solve my problems?... I don't think I have anyone who I can talk to.

Lourdes, however, has a strong faith in God, whom she believes helps her when she needs it most. Lourdes grew up Catholic, and continues to attend church regularly, although she acknowledged that the reason she attends mass regularly is because her youngest son is about to receive his first communion. She described her belief in God and in her Catholic faith as follows:

Well, what you would say going to church every week, well, yes I go, but only because my son is studying for his first communion. I have my faith. My Catholic faith. But my faith, my relationship is direct. I feel like I don't have to go to church. I go every now and then. But for the last 2 years I've gone every Sunday because the church requires it because he has to go. Because if they go the parents

also have to go. So it's been the last 2 years. Once he does his first communion, I won't go again for a couple months. But it's like I said, I think my relationship is direct. I don't need to go to church. I know that wherever I am, if I ask from the heart, He will listen… Sometimes I think that some way or another God listens.

Lourdes also revealed that although she may not feel she has to attend church regularly, she does feel like she can count on her priest by talking to him, stating, "I feel like spiritually it would help me a lot." She went on to say that sometimes she feels that perhaps she has not really developed as a mother, and that a priest might be able to give her guidance.

Lourdes' two teenaged sons, ages 16 and 17 years, are currently in high school, and have both been identified by Special Education services as having a learning disability. Recently, both of her sons were identified as having an educational need for counseling for a number of emotional and behavioral problems. Furthermore, both of them are in a behavioral program that monitors their behavior, as well as on a behavioral intervention plan to address behavioral problems that include noncompliance and anger outbursts. When asked about the counseling support her sons were about to begin to receive, she stated, "I would love that. I would love for them to both get it." She reported this pleased her because she believed her sons had a real need for counseling services. In fact, prior to the school offering counseling services, Lourdes had already sought counseling services in the community for her 17-year-old, saying:

I went to the clinic and I told them about how he was and they referred me to- I say she's a psychologist but maybe she was a counselor. And that's in the clinic

on R and S streets. And I would take him every week. And then I stopped taking him because he told me he was feeling better. And then suddenly he will say, "take me to see that lady. I talk to her and I feel good."

Overall, Lourdes is a woman who, despite being a recent immigrant with limited English proficiency, was able to find the help she needed for her son, and is open to obtaining help through the school. Lourdes was also open to seeking spiritual guidance from a Catholic priest. Lourdes, however, is not one to turn to her family for help as a result of her being the oldest, and the one people turn to. With regard to the use of *curanderos* for problems adolescents face, Lourdes became reticent, saying, "I simply don't believe. I don't have anything to say," and did not elaborate more.

CHAPTER 5: Results

The grounded theory analysis of the 27 interviews revealed considerable consistency in the participants' views regardless of family history, adolescent problems faced, language spoken, and their generation in the U.S. The primary outcome of these analyses is a model describing the relationships between families and resources available to them, and the impact of these relationships on the likelihood of a mother seeking out such services or help in times of need, particularly for when adolescent problems arise. This process can be summarized as *evaluating resources in response to adolescent problems*. Furthermore, there is an overview of participants' use, or likelihood of use, of the various resources available to them.

This chapter is organized such that first we explore how the model evolved, beginning with a summary of the research analysis, which includes the process of coding in the various stages, including open coding, axial coding, and selective coding. Next, a graphical representation and summary of the model that has emerged throughout the study is presented. The components of the model are then explored in more detail. Finally, information from the *curandero* and priest is integrated with data from the participants.

Development of the Model

The interviews conducted as part of this investigation were rich and detailed. The process of coding and analyzing the hundreds of pages worth of transcripts was at times daunting, as it appeared difficult to find a unifying theme that could capture the diverse

experiences the participating mothers had shared in the interviews. The categories that were coded were centered on perceptions of adolescent health and problems and their perceptions of the resources they believed were available to them. As the analysis continued, it was clear that all participants described going through a process of evaluating which resources to seek when a problem arose with their adolescent. There was also an expression of how being a Mexican or a Mexican American colored participants' perceptions of adolescent problems, and the way these problems were addressed.

At the most basic level, transcripts were analyzed to identify key words or phrases that participants were using to describe the phenomena. There were two major areas that were analyzed like this, including adolescent health and problems, and the resources available to them. For the first phenomenon, adolescent health and problems, there were words and phrases that most participants were able to articulate. For example, in describing healthy adolescence, most participants used the word "happy" as a major characteristic. Other most commonly used words and phrases included "active," "no problems," "out of trouble," "involved with family", and "eating well." The opposite extreme, representing problems in adolescence, yielded more key words and phrases to describe that phenomenon, including "drugs," "gangs," "sex," "anger," "sadness," "rebellious," "truancy," and "dropping out."

In identifying these basic categories, it became evident that the participating mothers were aware of a more complex relationship between the adolescent and their environment that accounted for whether an adolescent was healthy or had problems. At

this point in the analysis, the other categories were identified that participating mothers believed contributed to the adolescent's well-being. For example, the most commonly cited factor in contributing to adolescent health and well-being was the concept of "family." With regard to factors that contribute to problems, participants reported negative family life (i.e. "parental problems," "divorce," "no support," "lack of supervision"), "peer pressure," and "stress" in schools.

The process of exploring participants' thoughts on resources available was also subjected to a process of basic identification of core categories. Participants spontaneously provided categories that included "family," "God," "my church," "the school," "counselors," and "professionals." Beyond the identification of these categories, it became evident participants were applying a process of evaluation in determining whether those resources were something they were willing to seek out. Participants related "cause and effect" descriptions that helped put the choices the mothers were making into context. For example, some participants described that they would turn to family, "because they have gone through it," indicating they would find it helpful to talk to some in their family based on their past experience. Similarly, some mothers were willing to seek help in schools stating, "Because they have helped me" in the past. Others still expressed they would seek the help of a priest, for example, "Because they listen to one."

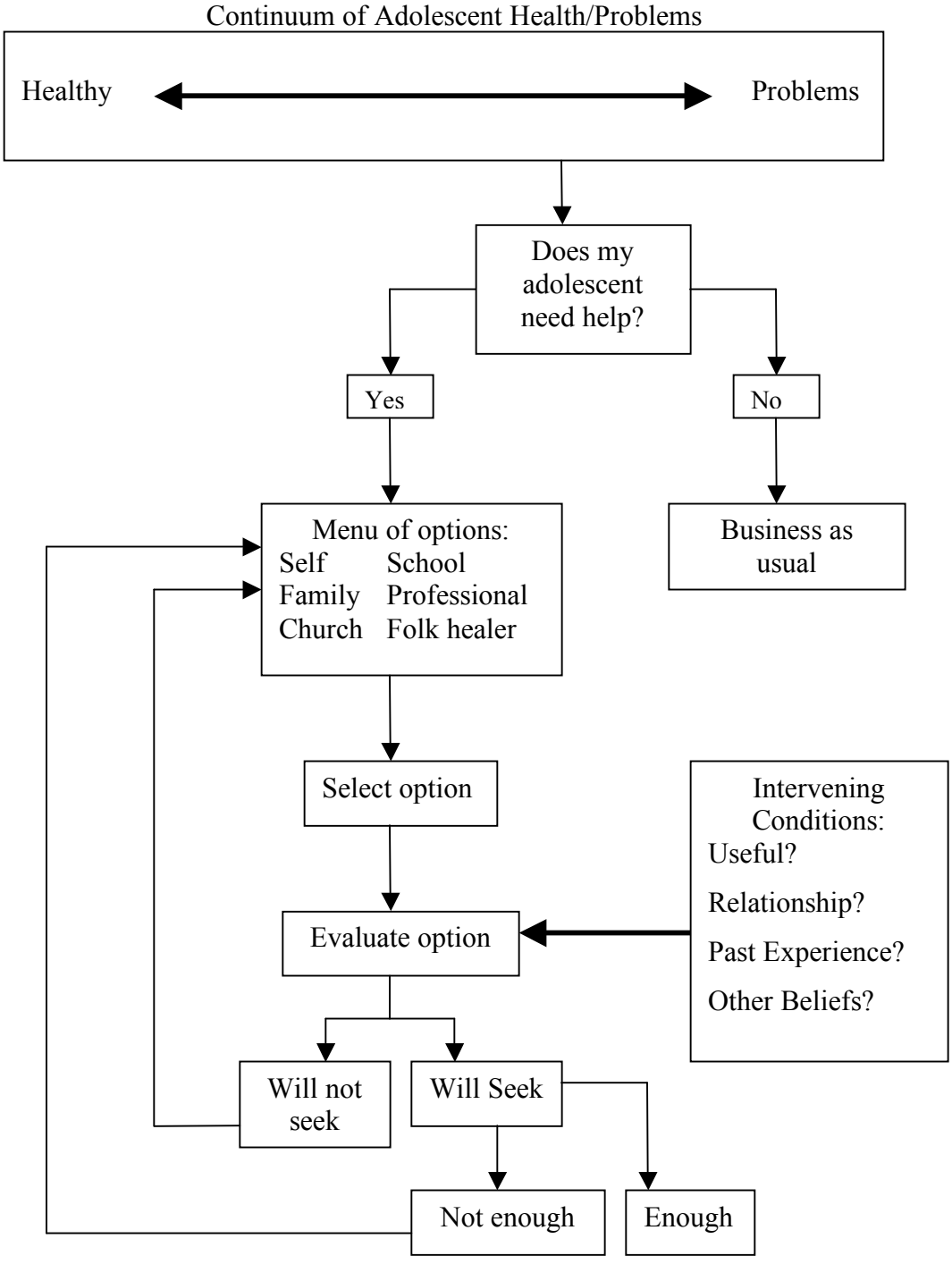
In the end, what developed after considering the relationship between the categories that emerged and the intervening conditions was a model that captured the dynamic process that is involved in Mexican American families seeking help for an

adolescent who is experiencing problems, or *evaluating resources in response to adolescent problems*. The next part of this chapter explores the model, and each component of the model, in more detail, illustrated as much as possible with the participants' own words in the interviews.

The Model

The central concept for the model is *evaluating resources in response to adolescent problems*. A graphical representation can be seen in Figure 5.1 on the following page. It depicts the process that a mother goes through in determining the services she is going to seek out for her adolescent. It should be noted that at various points in the model, the *Mexican American experience* influences the decicion-making process and steps a mother takes. This will be highlighted in each of the sections where it is relevant.

Figure 5.1: Mexican American Mothers' Help-Seeking for Adolescent Problems: Evaluating and Selecting Resources in Response to Adolescent Problems



The graphical representation of the model is a decision flow chart where the first step involves determining whether the adolescent has a problem that the mother deems is severe enough to seek out some type of service in order to help the adolescent. Upon determining that the adolescent does, indeed, need help, the process begins by selecting from a "menu" of options that the mother considers to be available to her. It should be noted that this is a dynamic process that can occur in a simultaneous or stepwise manner where a mother may either go through the selection and evaluation process one resource at a time, or she may simultaneously activate the process for two or more options.

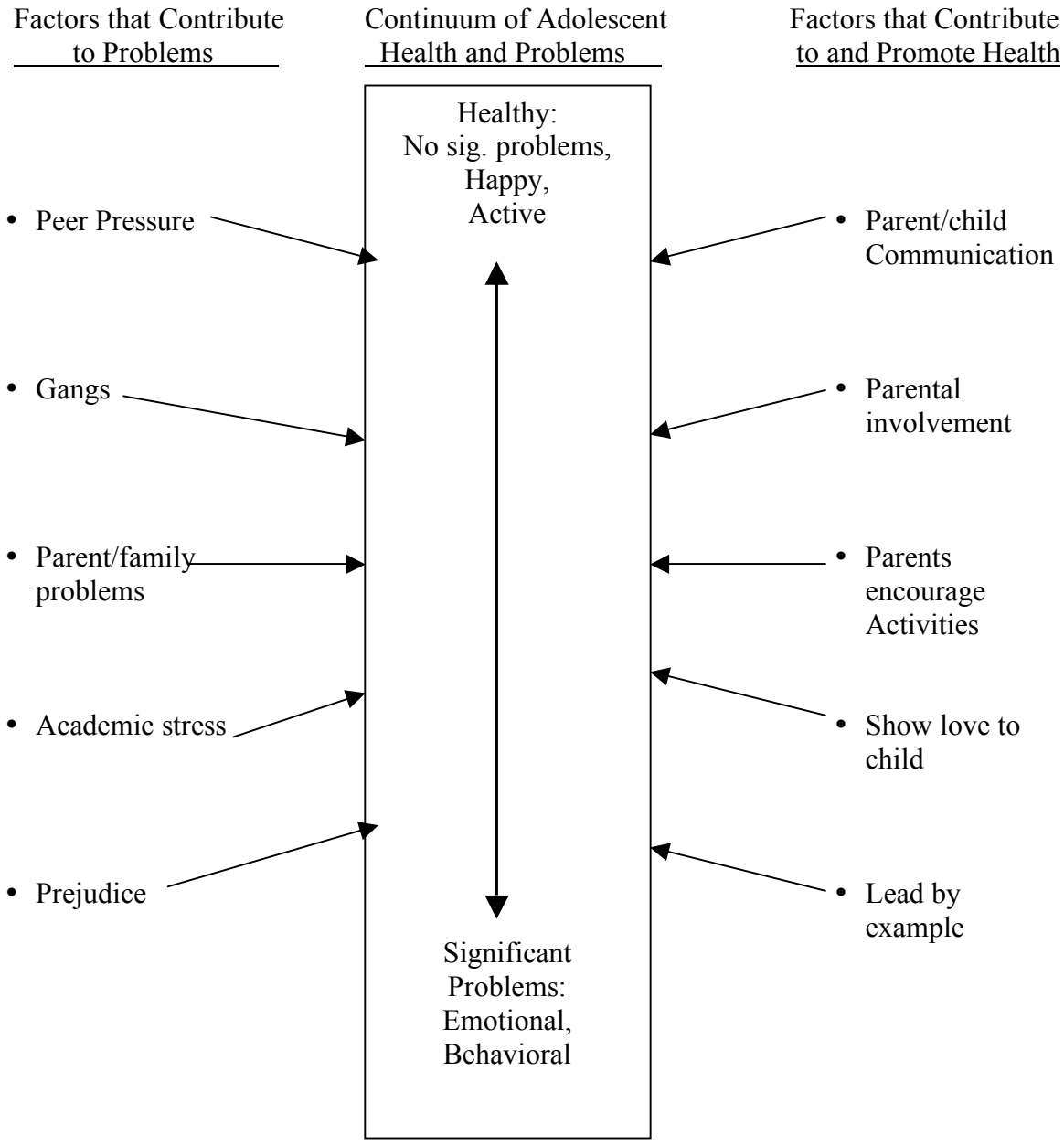
At that point, the mother makes a selection, or selections, from the available resources and subjects her selection/s to a process of evaluation via certain intervening conditions. When enough conditions are met, the mother makes a choice of seeking out that resource to help her adolescent. When those conditions are not met, the mother makes the choice to not seek out that particular resource. At this point, the process reverts back to the step in which she selects another option from those that are available. The new selection is then subject to the same evaluation process, and again another decision is made to seek or not seek that particular resource.

Sometimes, a mother determines that a selected option is enough and the process of seeking out help stops. Other times, however, it is determined that a previously selected option may not be enough in addressing the problem the adolescent is facing. At this point, the process of selecting and evaluation a new choice begins. The following is a more detailed exploration of the steps involved in the model.

Participants' Evaluation of Adolescent Health and Problems

The first part of the model involves the *evaluation of adolescent health and problems* in order to determine whether an adolescent needs help. For participants in this study the evaluation of adolescent health and problems begins with a description of what "healthy" is and what a "problem" is. As described in chapter 2, the literature on the problems adolescents, and Mexican American youth in particular, indicates there is a range in manifestation of such problems. From behavioral, to emotional, to academic problems, there can also be a range in severity. The participants in this study impressively had their finger on the pulse of adolescent life and very closely mirrored what the literature describes as problems adolescents today face. Furthermore, participants described the factors they believed contributed to adolescent health or problems, indicating factors ranging from family, to schools, to peer pressure. Figure 5.2 illustrates the participants' conceptualization of the continuum of adolescent health or problems, and the factors that contribute to health or problems.

Figure 5.2: Determining Level of Problems: Perceived Factors that Contribute to Health or Problems



Picture of the healthy adolescent. To begin with, the participants in this study articulated their perception of adolescent health. Despite being asked broadly and then more specifically, most participants were able to spontaneously articulate responses that captured the range of characteristics and various areas of adolescent functioning that could be seen as representing health or well-being. Almost universally, there was conceptualization that included not just physical health, but also emotional health that could be seen in various aspects of adolescent life and functioning.

Characteristics of healthy adolescents included being happy, physically healthy, emotionally healthy, and being well provided-for within the family. For some mothers there was a focus on, "Always being in school, doing better, being able to communicate with people, always smiling," as described, for example, by Silvia. Her focus hinted at the importance of education, as well as being happy. Similarly, Sara echoed that sentiment by stating, "Healthy, well, that might be that he's relaxed or is more happy. More comfortable and can think more about school or no problems or things like that. And that he sleeps well, and is well and all that." For some participants, there was an understanding that in order to accomplish the academic tasks in school, there needed to be a sense of well-being, seen and described as happiness. There was also a conceptualization of health as the absence of problems, as captured by Sara's quote.

Other participants conceptualized adolescent health within the context of family life and functioning:

> Maria: What is healthy? Talking to him. Having those talks with him, go fishing with him, it's the simple things. Right now we have a big problem. We've got two

parents who work day and night trying to provide for their children and don't make any time for them. And that's the biggest issue. They're not taking the time out. They're not having the dinner with them to say "what did you do today?"

This conceptualization of adolescent health within the context of family life and involvement is discussed further later in this chapter as we explore participants' thoughts on the factors that contribute to health in adolescence. It is mentioned here, however, because this was a common way in which participants described adolescent well-being.

Perhaps the best articulation of the overall conceptualization and "picture" of a healthy adolescent comes from Maricela, based on her experience with her own children. She eloquently stated:

I can talk about my kids. I think-- well, healthy includes a lot of different things. From their physical health, to their mental health, their emotional health. Those are kids who have healthy meals. And also of healthy mind. By that I mean that they are not thinking about unpleasant things like drugs. Thinking about vices. And well their moral, mental health. That they are good kids. Respectful. With their families, with their peers. That they honor their parents. You could say that's a healthy child. And in my home I think that maybe I don't have the most healthy kids physically because I can't control the way they eat. I try to-- and I can generalize based on the four I have. And I don't know if it's because it's so easy to get food out there. But from there I think that my kids are well mentally. We have a lot of communication with them, and any problem they have we talk about. They are comfortable with us. But I definitely know that they are going to

> talk about what they want to… And so I think, why not give them a hand if there is something they need? No matter how big the problem, that's what we're here for. And so, but in the end they're going to tell me what they want to.

Maricela's explanation of adolescent health or well-being encompassed a range of areas of adolescent life and functioning. Like most other participants, she sets up the context of adolescent health within the family, which is a good segue into our next discussion, which is the factors that contribute to adolescent health.

Factors that contribute to health in adolescence. The central theme in describing the factors that contribute to health in adolescence was the concept of family involvement in the adolescent's life. Participants related that there were many ways in which families, and parents in particular, could play a role in adolescent health and well-being. Participants reported parents promoted well-being in various ways, such as by providing love, guidance, attention, and advice, as well as by being involved and communicating with their adolescent.

Perhaps the most prominent of these was the concept of providing love to their adolescents. Love could be manifested in a variety of ways, from physical affection, to showing love through some particular action, such as spending time with them. Soledad, for example, conceptualized adolescent happiness as related to love as follows:

> I think the biggest thing with the child is they need to be happy. They need to know that they're loved and unfortunately parents get so involved in other things. Personal, what they have going on in their lives. And sometimes the kids don't always get the attention or the time. Maybe not necessarily attention, but the time

> they need with the parent. I know for me, me being that I have three of them, I have to make time every day, you know. Luckily my youngest ones go to bed a little earlier, and when they go to bed me and my older one sit and read, or we do puzzles or whatever. I have to make time for each one.

Others, like Lupita, echoed the sentiment that spending time with her children was a way of demonstrating love, which in turn promotes the adolescent's well-being:

> We want them to have a stable family, and you know give them the education they need. Give them a lot of love. That's something that we believe. That, you know, we express our love for them. You now, not only by hugging them, and telling them, but spending time with them. You know we try to take them out and you know spend time alone with them. You know, on one-on-one basis.

Another major contributor to adolescent health was the concept of parents communicating with their children. Some participants related this in broad terms, such as, "It would be nice if everyone just would communicate with their kids. I think that's the most important thing in the family. Love and communication." Other mothers had more specific thoughts on how communication between adolescents and parents. Leticia, for example, stated, "If I find anything [is wrong] out I usually ask. Go find out what's going on with him. See if I can get anything about what is bothering him," indicating that she used communication as a means to becoming aware of what an adolescent is experiencing.

Another aspect of communication was seen in the giving of guidance or advice to adolescents. The idea of providing advice to adolescents came in two ways. One was as a

way of teaching them the things that the parents values, and the other involved providing advice in response to something the adolescent had done wrong. Sandra, for example, brought up advice in the context of teaching them that she values their being drug-free:

> Well, for my children, my two adolescents, the most important thing is that they don't use drugs. I think. And that we talk to them about the consequences and give them examples of people who use drugs and the types of problems that they get into. And well, talking to them, more or less. There are times one talks to them and they don't understand anyway.

In this example, the mother also incorporated the idea of warning adolescents about the consequences that come with certain actions they may take, and in particular with using drugs.

With regard to using advice to deal with problems that already occurred, one mother, Sandra, described specifically talking to her daughter about the incident, and how to change thing in the future:

> And I talked to her. I asked her what is happening. Because they would call me from the school, "We called to tell you your daughter is being punished because of this and that." And I would get to school and tell her, "Why did you do this?" And she would stay quiet and wouldn't say. She would just cry. And I told her, "Why? I tell you to behave." And my husband and I tell them behave, don't get in trouble. I tell her, "We work. Your only job is to study and help with household chores." And I tell her, "It's not much. We're not sending you to work. We're

> working so that we can give you- try to give you the best we can. And your only obligation is to study. And that you don't get in trouble."

This participant gave a very detailed example of some of the dialogue she uses in giving advice to her adolescent daughter. The aim of her advice was to have her daughter avoid getting in trouble any further. Her example of advice, however, could be construed as more of a "lecture" than advice, but this was a common perception of advice-giving among many of the participants.

Several participants, in addition to giving advice to their adolescent children, also practiced the concept of leading by example. The idea was that if an adolescent is to truly be expected to not do something the parent says, the parent, too, should be expected to uphold those expectations and values. For example, in expressing her expectation that her children not use drugs or alcohol, Laura reported, "I tried to teach them-- at home there has never been alcohol, and much less drugs." Here, Laura shows us that for her, the teaching does not come through simply telling the adolescent what is expected, but by actually practicing it herself as well. Selina expressed this was particularly important because an adolescent might not be inclined to follow a parent's guidance or advice if they felt their parents were not living up to the same standards:

> And like for the boys, once they're a little older, well, we want them to not be hanging out with bad kids who could encourage them to drink or drugs, whatever, all of that. And then find out that their dad is doing that. For example if he's a drunk and a drug addict, how can you tell them "don't do this" if he is like that? And like that they have the right to ask.

Perhaps the most prevalent of factors that participating mothers perceived as promoting adolescent health was the concept of being involved with their adolescents. This was most commonly expressed as spending time with them, engaged in a variety of activities:

> Silvia: Even if you don't have a lot of money, just spend time with them. Go throw a ball. That's what we would do if there wasn't a lot of money. Go to the lake, take them out, just to go get some sun, you know? Things like that.

> Maricela: We are a very united family. Among ourselves. My husband, my kids. We spend a lot of time together. We are interested in sports. We don't drink or smoke. We love sports. We always have encouraged the kids to play. Actually, right now C plays volleyball at the HS. Since middle school, she's been in basketball, volleyball, cheerleading. And she is the only girl we have, and the three boys are a little more lazy, but we-- I think we are their models. Wherever we go, we participate in things with them.

There were several participants, however, who pointed out that despite being involved parents, there was a chance that despite those positive family factors in an adolescent's life, there was still a chance that those things were not enough to completely shield an adolescent from developing problems. One participant who experienced a number of serious emotional problems with her daughter, including an attempted suicide that led to a psychiatric hospitalization, had this to say:

> Luisa: I'm here. I work all day, but I'm still involved with my kids 100% with them… Yes, I always have them around me. I've always took them to church. They've been with me to the movies, I'm there. So I ask myself, where is it that I went wrong?

Other participants echoed this sentiment, indicating that while they were aware that these aspects of family functioning were beneficial and necessary in an adolescent's life, they were not enough to guarantee complete health in adolescence.

While participants readily provided examples of the way families can contribute to the health and well-being of an adolescent, it is interesting to note that none of the participants were able to describe any factors that were not related to the family as factors that can contribute to adolescent well-being. This is particularly striking because, as it will be seen in the next section, participants were able to identify non-family factors that contribute to problems. Participants, however, were not able to identify ways in which these other factors could positively affect an adolescent.

Picture of the adolescent with problems. As with the descriptions of adolescent health, participants were readily able to articulate the problems they believe adolescents can face. There was a range from emotional to behavioral to school problems. There were also reports of a combination of multiple problems at once.

With regard to the emotional problems, at the most basic level, participants described that adolescents could experience "sadness" or being "depressed." This particular emotional state was typically mentioned in the context of a change from an adolescent who was previously not sad, but began to appear sad over time. For example

Sandra reported that she noticed a change in her son, which was first evident in him getting in trouble at school. After a number of suspensions and encounters with law enforcement officers her son "Was very sad for a long time." Another participant, Lourdes, reported about her 17-year-old son that, "He's been feeling bad or depressed," on and off, and that she can usually tell by the way he treats other members in the family.

Many participants also responded by describing a change in their adolescent's "attitude" that was markedly different from they way the adolescent used to be. This was usually the first indication a participant had that there was something "wrong" with their adolescent. For example, Sofia described it as:

> Their attitude. Their change in, how can I say? They say that it's a change when they change from child to adolescent. Their attitude. That you can't talk to them anymore because they now talk back. I tell you in my case because that's what happened with my son when he was entering adolescence. I couldn't tell him do this because he would yell at me. And the same with my daughter. My son has calmed down a little. Now it's her.

Other adolescents can demonstrate emotional difficulties in their low "self-esteem," as several of the participants reported. Leticia, for example, became aware of her adolescent's low self-esteem as a result of the comments she heard him making about himself:

> Sometimes he tells you things that hurt you like, "I'm still an idiot." Or "Why am I the only one who was born with a mixed up head. I'm crazy." And I tell him he's not crazy. And that makes me sick. His self-esteem, he brings it down

himself. And I tell him not to lose hope. Don't give up. You can do it. If you want it, try it and you can accomplish it. And he says, "Nah, I'm not going to do anything. I'm stupid and I can't do anything I want." He brings himself down.

Others see the most extreme side of an emotional problem in adolescence, where the child is not able to cope with the difficulties they are having and as a result considers ending her life. While not a very prevalent problem, it was such a significant one reported by several participants that it merits addressing. For example, Lourdes reported, "And I try to say something to him and he starts crying. He says he wants to run away, that he would rather kill himself." Another participant reported an experience with her daughter where she actually made a suicide attempt that required a psychiatric hospitalization:

Luisa: Well, my daughter, my 14-year-old, [tried to commit] suicide when she was, well a year ago. Because we didn't let her go to a party.

Investigator: Oh, so what happened?

Luisa: She drank a lot of pills and she went crazy.

Investigator: Oh, I'm so sorry.

Luisa: So that was a scare. Now she thinks that oh, my God, if we don't let her do something you know, she's gonna threaten us with that. So she has us by a string.

Investigator: Boy that's really powerful, too.

Luisa: Yes. Very. You don't know how these kids are gonna react.

In this particular example, the adolescent's emotional distress was enough to lead her to actually take the action of attempting suicide. This in itself was seen by the parent as a significant signal that there was a problem. This particular adolescent, however, then

became aware of how powerful a threat suicide was, and began to use that. This, too, was experienced by the mother as a problem because it indicated she then had the potential to manipulate her parents by threatening do to that again.

The problem of drug use was also one that was reported by many participants, whether they had first-hand experience with their own child, or were aware of the problem in other adolescents. Whether bringing up drugs as a sole problem, or in the context of gangs and peer pressure, all but two participants mentioned them as a significant problem adolescents face. The participant that spoke most at length on the issue of drugs was Laura, who had experienced a drug problem with her 17-year-old son that she considered very serious:

> That's when you get to know when your kids are using drugs. Because your kids change. I tried to teach them- at home there has never been alcohol, and much less drugs. And then when you see with sadness that you get home and your kids is already in a bad mood. When you used to get home and your son would greet you, how are you? Are you hungry? He was there for me. And you say, oh, what happened? He doesn't even look at you. And he's stuck to the TV. And where is that child who used to be there? Where is that child? And that's when you notice what a lot of parents don't want to see. I tell them they need to tell me if they're doing stuff. And a lot of times they hide it, but you can tell with their attitude.

Another problem that emerged as a significant concern was adolescents having sex. Whether it was seen as a problem because adolescents are not mature enough, or because it could lead to unwanted pregnancies, all participants who mentioned sex,

reported it as a problem. Luisa, for example, expressed concern that her daughter was feeling a sense of urgency to rush into to have sex saying, "If a girl, 14 years old, doesn't have sex, she's not a good girl (laughs). It's like sex is gonna finish by the time they're 18 if they don't do it." Another participant, Sonia, who was a recent immigrant from Mexico, expressed a concern about sex in the context of adolescents having too much freedom to choose to have sex without realizing the consequences:

> Well it's because like in Mexico we have another opinion about sexual relations. And then here it's like I feel like it seems easier for them. And aside from that like they have more liberty, and so then that would be a problem. Well then come the unwanted pregnancies.

Although the problems adolescents face have been discussed individually, most participants described problems in combinations, such that when a problem was reported or conceptualized, it was usually in the context of other problems or concerns. For example, participants commonly mentioned the use of drugs within the context of gang involvement. Lupita, for example, believed "And you know just getting involved in gangs… after that comes the drugs and the drinking." Another participant, Selina, expressed concern about drugs because she believed they could be a gateway to other, more significant problems, saying, "Because it leads to a lot of things. Stealing, killing. Gangs. They go on to big things." Regardless of the combination of problems, it was evident participants believed adolescents were at risk for multiple problems at once. Furthermore, as with the factors that contribute to health, participants were able to

describe in detail factors that contribute to adolescent problems, which is what the discussion turns to now.

Factors that contribute to problems in adolescence. Unlike the factors that contribute to health in adolescence, which were centered on family involvement, the factors that contribute to adolescent problems were varied. While there was an emphasis on the way families could have a negative impact on adolescents, there were other factors, including peer pressure, the presence of gangs, academic stress, and prejudice, as related to being of Mexican descent.

The concept of families affecting, or contributing to, adolescent problems was often seen as being due to parents *not* interacting with their adolescents in the ways that were described in the section on factors that protect adolescents. Whereas the positive aspects of family life, including parental involvement in the child's life, communication, showing love, leading by example, and encouraging activities were seen as factors that contribute to health, the more negative aspects of family functioning were considered factors that could negatively impact an adolescent, therefore contributing to problems. A commonly stated factor, as Sandra reported, was, "Because parents fight. Because parents are separated," indicating that problems between parents could affect a child's well-being, leading to emotional problems or problems in school. Divorce and reintegration into a different family composition were also cited as factors that contribute to emotional problems. Lidia, for example, stated that, "there's people getting married one, two, three times, not getting married, but just living with different people, bringing all these kids to you know a new living environment and they get mad. They're mad." Others focused on

how parents were sometimes unable to provide their adolescents the time and attention they need in order to be free of problems. Silvia stated:

> It could be because of the parents, they don't pay attention to them. They're drinking, or they're just too tired working day and night. Maybe a single mother or a single father. I mean it's hard… They don't get the attention, I believe. They don't get that affection that they need from the mother and the father. And if they don't get it from the mother and father they'll get it from somebody.

In this particular example, the participant was describing how the lack of a parental presence in an adolescent's life could lead to them feeling alone and needing to fulfill that gap in their lives in other ways, including drugs or gangs. Another participant described how various aspects of family functioning could contribute to adolescent problems:

> Yes, well, there are lots of reasons for kids to have emotional problems. For example, when they see their parents fight. Or when one ignores them. Not talking to them, that they don't have a level of comfort with them. I think that hurts them. Boys and girls.

In this particular example, the participant included a number of ways in which an adolescent could be negatively impacted, including parental problems, lack of communication, and lack of time spent with the adolescent. Her conceptualization highlights the fact that parents experience family life and parenting as having two sides. When family life is stable and parents provide love and attention to their children and communicate with them, the adolescent experiences those things in a positive way, and is

therefore protected from problems. When an adolescent experiences the negative side of family life, they were thought to be more likely to develop problems.

Yet other participants related the fact that they were Mexican, or had what they believed was a uniquely Mexican approach to parenting, to some of the problems they saw in their adolescents. Marina, for example, described a problem she had faced with her daughter, as a result of her father's attitude toward a boyfriend he did not like. She said, "And her father being the way he is- pretty Mexican- he was very upset and did not allow that boy to come *near* this house again." Her daughter, upset with her father's attitude, continued to see the boy, and her grades started to drop. In Marina's opinion, her husband's attitude contributed to her daughter's academic decline. Another participant noted that Mexican or Mexican American parents can sometimes contribute to problems in the way they "baby" their children. Maricela stated:

> I think a lot of us Mexicans do this. Mexican women do that. We baby our children… And I think that's where (my son) is at right now. He needs someone to take care of him and I don't want to do it. I want him to go out there and do it yourself.

In her opinion, Maricela's previous approach to parenting her son, in which perhaps she did not give him enough autonomy to learn to be independent, was negatively impacting his ability to take care of himself.

Aside from the negative aspects of family life that contribute to adolescent problems, perhaps the next most prevalent factor that was reported was *peer pressure*. All participants reported some level of peer pressure, whether to try

drugs or sex, or to look a certain way, present in all adolescents' lives that could have a negative impact on their functioning. One way peer pressure was seen as negatively impacting children is in the way adolescents are made to feel they need to be a certain way, engage in certain activities, or look a certain way to fit in, or else get teased. Soledad, for example, stated:

> I think there's a lot of peer pressure. Kids these days are just mean. Kids get made fun of for everything. If they wear glasses, if they're too heavy, if they're too skinny, if they have braces, if they're too tall, or too short. Kids get picked on a whole lot.

Many parents reported similar concerns, and were also clear in stating that this was a gender-neutral problem, where adolescent boys and girls are faced with the same pressures. For example, Macrina, whose 17-year-old sons were on the football team, reported that they were increasingly pressured to look a certain way in order to fit in with the rest of the football team. She stated, "So I think it's just like they say about girls, they see girls in commercials that they look slim and beautiful and I think it hits the boys too in certain ways that they should look a certain way to be successful. Or do well in life." Perhaps a more serious consequence of being pressured is that an adolescent is made to feel like they need to engage in certain activities, which parents consider dangerous. Marta, for example, reported that she was concerned because of some of the things her sons were experiencing, stating, "They even told me about times when other students come and approach them and, or you know, are teased because they are not in gangs or they don't do drugs or things like that." Marta expressed she was worried that by being

teased like that, her sons could become more susceptible to seeking out those things. Another participant expressed concern over the fact that her adolescent was being pressured within the school environment, and that within that environment is where many adolescent gain access to drugs. Laura stated, "But I think that here (at school) is where they learn about drugs. That's one of the things they have more access to here." Finally, another aspect of peer pressure that was reported by participants was the idea that adolescents could be pressured into having sex, which could lead to unwanted pregnancies. Lidia reported, "But there's nothing in her little world that I tell her that this boy just wants to have sex with you and then dump you. There's so many 14, 15 year olds pregnant out there. I see them every day at work." In this example, the participant highlighted how her warnings as a parent were not enough to counteract the pressure her daughter was feeling from a boy she was interested in.

Another factor that almost universally came up in the interviews was the idea of the presence of *gangs* negatively impacting adolescent functioning. Whether in feeling the pressure to join, or in the actual risks of being in a gang, participants were clear in reporting that gangs were a bad influence in adolescent's lives. One participant explained that at times, the pressure to join a gang could be greater than the positive influences in an adolescent's life. Lupita stated, "(Gangs are) one of the problems I've seen with people, you know even people close to their kids. You know, people are trying to raise their kids good. But I guess it's just the peer pressure." Others expressed concern that even when not directly pressured, the presence of gangs, particularly in schools, could be troubling for adolescents. Selina, for example, reported that her daughter was scared

because, “in the bathrooms there are lots of letters and words, and they know what means,” indicating her daughter was aware of the presence of gangs even within the school setting that was disconcerting to her daughter.

While the factors that have been discussed thus far could be considered universal in that they can affect adolescents of all ethnicities and backgrounds, there was one aspect of being an adolescent of Mexican descent that was reported as negatively impacting adolescent functioning, which was *prejudice*. A number of participants, particularly those who were recent immigrants from Mexico, reported incidents in which their child was made to feel they were being singled out because of their ethnicity. Sandra reported about her son:

> He got into a fight with a kid in the bus. He got tired. My son said that he would call him *mojado* that he would call him “wetback” and that he would tell them bad things, and bad words. And I said, “Well, what did he say?” And he said, “Well he said bad words, so I can’t tell you what he said.”

Participants also reported, however, that that the prejudice that some of their adolescents experienced was at the hand of other Mexican American adolescents, or “Hispanics,” at school:

> Selina: Well, they have problems with racism. Racism.
>
> Investigator: From whom?
>
> Selina: Amongst themselves. For example, the Mexicans and the Americans. They have problems. How can I say? They don’t like each other. And so I think that that is a problem they face in schools. And even if they speak English or

> Spanish, because sometimes they don't like for the Hispanics to speak Spanish there. Because my girls tell me about that and that's why I'm telling you they have that problem at school.

With regard to how this prejudice affects adolescents emotionally, participants reported that it could affect them in the way they see themselves, and could eventually lead to feelings of sadness or inferiority. Laura described her adolescent's experience and the effect it had on him as follows:

> It's something that sticks with them, because many time I've had to deal with my kids coming home crying. My oldest one time asked me what a wetback is. I told him that we are Mexican and that he should not be paying attention to that. "But they said I was Chicano" I said, "What's the difference? Mexican, Chicano, Chinese, Black? What's the difference? You think their blood is different? No. We're all the same. When that happens, just ignore them." But they have that a lot in schools.

Again, it should be noted that the participants who reported incidents in which their adolescent had experienced prejudice, or what they described as "racism," were all recent immigrants who themselves only spoke Spanish.

In addition to the acknowledgement that a lot of the problems related to drugs, gangs, and peer pressure occur within the context of the school, mothers also expressed concern about some of the academic issues that students face. Difficulties with learning or focusing in school were prevalent:

> Mayra: Well there's some kids that it doesn't matter how much they try, they just can't get something in their head, for example, to start an essay or to start just a problem, in the beginning of a problem. But and some kids just don't test well. They're very intelligent, but when it comes to tests they just can't. They can't. They can't do it or won't do well.

Furthermore, participants brought up the pressures that students today face due to high-stakes, state-mandated examinations. In Texas in particular the Texas Assessment of Knowledge and Skills (TAKS) test must be passed in order to graduate from high school. Schools are receiving increased pressure from the state to improve scores and passing rates, and this pressure is trickling down to the students, such that they have become increasingly concerned and worried about their scores. Soledad articulated this problem as follows:

> And I know the TAKS is a thing that has stressed a lot of these kids out. Worried about passing and failing and, well, you can pass your class but if you don't pass this test you're not going to the next grade. And unfortunately that's a big blow to child's self esteem to where they think they're in class to learn, but they're in class to learn to pass this test not necessarily to learn other information. And I think kids have to deal with a whole lot more.

It can be seen that the perceived stress brought on by the examination itself extends not just to worrying about passing or failing, but goes deeper such that it can affect a student's self-esteem.

One participant also explored how being of Mexican descent could have an impact on an adolescent's participation and focus in school.

> Maria: the school, man, they don't want to learn. They're not learning. They're not being really participants. Hey, you know, they've got these two worlds to travel between. And the easier road it's the one that's most traveled. And I think- what is the dropout rate for Hispanics? When will you ever see a Hispanic president? We've already accomplished what? We have a woman candidate for president, a black man running for president. That's historical. A woman and a black man. Do you see any Hispanics up there? No. Why? Because they don't strive to rise above.

In this example, the "two worlds" Maria is referring to are being Mexican and being American. To Maria, these are two worlds that are difficult to navigate between for adolescents, and as a result they can get to be complacent, and not "strive" to be more.

In summary, participants in this study demonstrated an awareness of the types of challenges adolescents face. They had a clear idea of what a healthy adolescent looks like, and the types of problems adolescents could have. Participants also expressed strong opinions on the factors they believed contributed to either health or problems. The idea of families affecting adolescents in either positive or negative ways was the most commonly reported concept. While family life was seen as two sides of the same coin, where positive family functioning was good for adolescents, and negative family functioning could be harmful to them, other factors were not seen as having the potential to do both good and harm. Other factors, including peers and schools, were only seen as negatively

impacting an adolescent's functioning, and were not considered to offer any benefit in promoting adolescent well-being. Furthermore, while some of the factors that participants identified as negatively impacting children could be considered fairly universal to all adolescents across ethnicities and backgrounds, there was one distinct challenge specific to Mexican American youth, and that was the idea of ethnic prejudice being present in their peer groups within the school and the community. Participants, overall, also had a good sense for whether their adolescent was healthy or was experiencing some problems. At this point, we move on to the next part of the model, in which participants take the first step, which is determining whether their adolescent needs help.

Does My Adolescent Need Help?

One of the most important and first steps in seeking out services for an adolescent's problem is the mother's evaluation of whether the adolescent is in need of help. In this study, participants reported a number of ways in which they determined their child needed help. One of the ways that was most commonly reported, particularly by participants whose adolescent was receiving counseling services or had been placed at the alternative center, was through school contact. Other parents reported that they noticed a change in their adolescent. In most cases, some of these occurred simultaneously, as when parents noticed a change in their adolescent and were also informed by their school that there was a problem.

In this particular study, 9 out of the 27 participants had adolescents who were receiving counseling services at school due to emotional and behavioral difficulties. In their case, the special education department had, at one point, determined that the

adolescent was demonstrating an academic need for counseling services. That is, the emotional or behavioral difficulties the adolescent was facing were significant enough that their academic worth was being impacted, and counseling services were deemed necessary in order to help the adolescent make academic gains. None of the participants, however, became aware of their adolescent's difficulties solely on the basis of the school informing them. Rather, participants in this condition reported being concerned even before being informed by the school. For example, Lourdes reported that she had noticed both her adolescent sons were "depressed" or "angry" and therefore when the school informed her they wanted to offer both of her sons counseling services, she said, "I would love that. I would love for them to both get it," essentially indicating both she and the school were jointly concerned about the boys needing help. Others yet were the ones who determined their adolescent needed help and sought out services through the school. Lolita, for example, reported how she was the first to seek help because of her concerns:

> When I first got [my grandson] I put him in Lifeworks. Then I put him in MHMR. I wanted to find out what was going on. And now-- well, I had him in counseling for school. A lot of it was to find out how he's ticking. How his brain is going. What's making him do what he's doing. That's what I want to find out. That's what I want to know.

In this example, the participant had noticed some behaviors that were of concern in her grandson. She knew she was unable to deal with those problems on her own, which is what pushed her to make the decision to seek help through various agencies, as well as

the school. In her case, the school evaluated the situation and agreed with her that her grandson was in need of counseling services.

Other participants were moved to action based on the changes they noticed in their adolescents. Leticia, for example, said, "I try to be aware of him," indicating she would look for signals that there was something wrong with her son. She reported she could tell when he was "depressed" and she therefore took action saying, "I went to the clinic and I told them about how he was and they referred me to-- I say she's a psychologist but maybe she was a counselor." Similarly, Laura was moved to talk to her adolescent son to give him advice and seek help through the school as a result of the changes she noticed in him. She stated:

> He was very angry all of a sudden, very aggressive. He's very playful, but if you told him something, he would go off. Something simple you'd ask him and he'd say, "What, you can't do it? Don't you have hands?" And he wasn't Eddie. And that's what you start noticing.

Similarly, Sofia reported that she was motivated to seek counseling through an outside agency when she noticed that her son was "Very lazy, doesn't want to do anything. Or gets angry over anything. Or wants to be crying if I get after him. He's very sensitive. And then he's all upset. And he didn't use to do that." When Maria realized her adolescent daughter was using drugs she said, "And that's when I looked for help. I looked for counseling." Maria reported she had sought counseling through the school as well as through her daughter's probation officer, as she had already been involved through the juvenile justice system. Mayra, who dealt with her adolescent's problems by

talking to her, reported she was prompted to action when her daughter's "Grades just started going and going and going down." In this particular example, Mayra determined that her daughter's academic decline was due to a boy she was spending time with, and Mayra thought the best way to address the problem was to talk to her. Beyond that, Mayra did not feel compelled to do anything more in terms of obtaining help for her daughter because eventually her daughter broke up with the boy.

Other participants, particularly those whose adolescents had been placed in the alternative center, sought help as a result of being made aware by the school that their adolescent was experiencing behavioral difficulties. In some of these examples, the participants had not noticed any difficulties in the home, but when they learned the adolescents were experiencing difficulties at school, they became involved in trying to help their child. Some participants responded by going to the school. Several participants, like Sofia, reported going "To speak to the principal," or to the counselor. By becoming involved with the school, parents like Sofia, Laura, and Sara were made aware of what the concerns were, and used that to determine what else they could do to help in that situation. Other participants, like Soledad, responded by talking to their adolescent after there was an incident that occurred within the school. When her daughter was caught with drugs at school, Soledad's first response was "To get her home and [try] to get her to talk about it." Similarly, Sandra reported that when her daughter was placed in the alternative center for writing symbols associated with gangs, she stated, "I talked to her. I asked her what is happening."

Overall, participants made their decision to seek help based on various factors that indicated there was a problem that needed to be addressed. As illustrated in these examples, participants based their decision to seek help on behaviors they noticed, changes they saw in their adolescent, and based on information received from their adolescent's school. Once the participant determined there was cause for seeking help, they moved to determining the options that are available.

Menu of Options Available to Mothers in Helping with Adolescent Problems

A mother's first step in obtaining help for their adolescent is to determine what resources are available. In this study, participants were asked broadly first to get a sense for what they believed was available to them. The responses were surprisingly uniform, with participants consistently reporting they were aware of the use of family, religious figures, their adolescent's school, and other professionals in obtaining help for dealing with adolescent problems. The following are some examples of some of the spontaneous responses to the question regarding resources they had previously used or would consider.

Selina, when faced with behavioral problems at school with her adolescent son stated, "Well, I went to talk to the principal," indicating the use of the school in addressing the problem. Marina reported that her response when her son was faced with the unexpected pregnancy of his girlfriend was, "We talked to our priest. He said, well you know, he was giving us what he could help us with. Just information, like you need to talk to this person," which in turn resulted in the family seeking out family counseling services in the community. When Luisa's daughter was going through a difficult time

emotionally, which eventually led to a suicide attempt, Luisa reported, "Well, we took her to the hospital. And she was there for like 2 days." When Soledad's daughter demonstrated some behavioral difficulties in school, she reported that what she found helpful was:

> Being able to talk to my mom. Being able to talk to my daughter's dad. My son's dad and I are pretty close, so being able to talk to him. Just family, really, just being able to know that it's not just me. It happens to other parents. Other parents have to go through it. It's always harder when it's your own child than when it's somebody else's child. But just being able to talk, mainly to family is who I've turned to.

Although some participants had not yet been faced with a problem, particularly those who belong to the group in which their adolescent did not have a history of emotional or behavioral problems, they were nonetheless able to respond about the resources they believed they would turn to in the event a problem arose with their adolescent. For example, Magdalena indicated, "If I couldn't do anything to help him I would try to get him some sort of help. Try to get my family involved." Sandra stated, "Well, I think I would send her to a counselor because sometimes one as a parent is not able to talk with them. I speak for myself. Sometimes we don't know how to talk to them." Similarly, Magdalena reported:

> I have a doctor and I am very comfortable with him. I would go to my doctor to get some sort of guidance on what we need to do. So, I don't have any problems going to see the doctor (pause). Or even to the school to talk to a counselor or the

nurse (pause). *I* wouldn't be embarrassed. They're gonna keep it confidential. I mean that's your child. You're going to do whatever it takes.

As it can be seen in these examples, the mothers in this study indicated they were aware of a number of resources available to them, regardless of whether they had sought them. In addition to the resources mentioned in these examples, other participants indicated the use of parenting classes through the school district, support groups, boot camps, or agencies such as SafePlace or the local Mental Health/Mental Retardation agency.

The use of folk healers such as *curanderos*, however, did not come up spontaneously in any of the interviews. This, in itself, is an interesting finding because it is an indication that when mothers determine there is a problem their adolescent is facing, the use of *curanderos* does not appear to immediately come to their minds, and therefore it is unlikely that they would seek them. The following is an example of how the use of *curanderos* was introduced during the interview, and the participant's responses:

Investigator: So we've been talking about these types of people that you can turn to, like family, school counselors, or psychologists, or the doctor. What do you know about the use of folk healers, like *curanderos* or *hierberos*? What do you know about their use for adolescent problems like we've been talking about?

Lupita: Well, I don't know anything about it. I didn't know they existed.

Investigator: You didn't know what existed?

Lupita: The *curanderos* for kids. You know. I know that in Mexico they have them for like disease, like if this hurts *dejame curarte del susto* (let me heal you

> from fright)… But I don't know what they can do for a child that is going through emotional problems or drugs. You know, I don't think they use the *curanderos* for that purpose anymore. Maybe they did like years ago, in Mexico or you know. They probably thought that the kids were like possessed by a bad spirit or something, that they would do some kind of healing, you know. But I don't think they do that anymore. Not that I know.

Although most participants responded in a similar manner, indicating they would not seek the help of a *curandero*, there were three participants who reported they would be open to their use; however, even those participants did not spontaneously report their use or consideration. For example, Soledad did not list *curanderos* among the resources she would consider, but when asked whether she would be open to their use she stated, "I think it would be interesting to see what they have to say. I haven't done a whole bunch of research," indicating this is not an option that she had considered before.

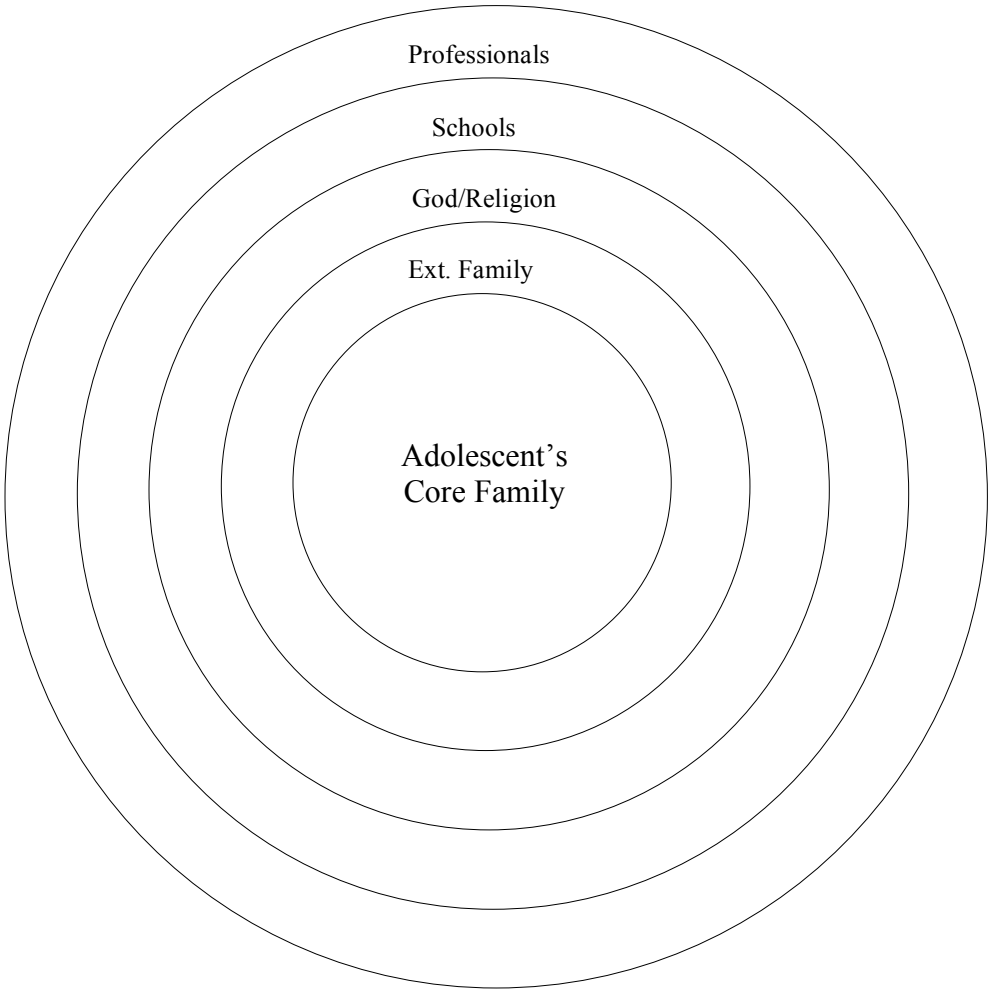
In summary, participants in this study reported the use of family, religious figures, schools, and other professionals for helping when problems in adolescence arise. Regardless of whether the participant had used a resource, there was an understanding of their availability for use. The use of *curanderos* or other folk healers, however, was never spontaneously reported by any participants as a resource in helping with adolescent problems.

Which Resource to Consider First?

Despite the fact that participants are aware of a number of different resources that are available to them, those resources were not necessarily all considered at the same

time. Rather, it appeared that participants had a system for determining which resource they would be most likely to consider first. For the majority of the participants, there were "layers" of resources such that they were more likely to seek out the resources closer and most accessible to the core family, and later consider other, more removed, resources. The concept of "layers" was borrowed from Bronfenbrenner's (1990) ecological systems theory, in which there is a "structure" to the environment in which a child develops. In this study, participants reported a sense of having these "layers," with the core family at the center of the system, and extending outward to parents' family of origin, followed by religious entities, such as churches, to the adolescents schools, and finally to "professionals" and outside agencies. An illustration of this concept can be seen in Figure 5.3.

Figure 5.3: Representation of the Core Family and the Order in Which "Layers" of Resources Available Are Sought



The "layers" in figure 5.3 were ordered based on the most commonly reported resources, or those parents would more readily access. While there were cases in which, depending on the severity of the adolescent's problem, mothers would seek out several resources simultaneously, for the most part, participants expressed a sense of a particular order in which they would deal with the problem. For example, Silvia reported that she would "start" with her husband, turn to her family, then talk to a priest, and then seek the help of a school counselor. Monica, in explaining what she has done in the past and what she would consider in the future, stated:

> Well, what I do is I talk to my kids. Give them advice. My husband and I do that. And then there is always my mother-in-law. She's been through a lot… And, you know, we read the bible and pray. So I might call someone in the church. Because you need prayer. And it has to do with belief in Christ and his healing. Because in the bible there are promises of healing.

When asked to consider what resources she would seek out to help her adolescent, Lupita reported:

> Well, there are people, professionals to help, of course. First there would be us in the family, my sisters. Second we would try our clergy in our church, the priest or somebody from there. And if they seriously recommended professional help, like a psychologist, I would definitely consider that. *If* I had to. That's my last resource.

Overall, it appeared that participants were more likely to seek out the core family first, followed by the extended family, the church, the school, and ultimately

professionals, in that order. This, order, however, is just a general guideline based on the most commonly given responses. Each participant, however, has their own set of experiences that make it such that the order might be slightly different, or that a "layer" is skipped based some intervening condition, as will be seen in the next section, which covers the evaluation process and the conditions that need to be met in order to seek out resources.

Evaluating Resources: To Seek or Not to Seek

Upon exploring the resources that are available for a mother in helping her adolescent, the next step that occurs is the process of seeking out help is *evaluating the resources*. This involves subjecting each resource the mother considers viable to a process of determining whether they meet certain criteria, which would then indicate the resource is worth seeking out. These criteria are those variables that define the broader context, and are known as intervening conditions, which act to facilitate or inhibit the presentation of the phenomena. In this case, those intervening conditions help the participant make a determination regarding whether to seek help from a particular resource they are considering. In this study, three intervening conditions emerged as the primary variables that influence a mother's choice. They include *expectation of usefulness, past experience,* and *other belief sets*.

Expectation of usefulness. Perhaps the single most important intervening condition is the *expectation of usefulness*. In this study, when participants described a resource they would consider seeking, they always expressed an expectation that it would

be useful or helpful. Different participants voiced their opinion on the usefulness of the various available resources, including family, schools, professionals and *curanderos.*

With regard to the use of family as a resource, some participants voiced they have turned to, or would be willing to go to, someone in their family because family could provide advice or comfort. Matilde, for example, stated she would turn to her family because, "they have gone through some problems and that's the way they can give advice. They can help." Silvia reported that when she experienced a difficult time as a result of one of her adolescent's incarceration, she turned to her family. She described that experience as follows:

> I had a lot of support that day. I had a lot of support. My family was there. My dad. My stepmom. My brothers, brother in laws, sister in laws, friends. A lot of support. Not only me, my son. And throughout the day people would call, "Are you ok?" My sister-in-law's sister had a son who was in prison, and she helped me out a lot.

Again, Silvia provided an example of how her family was helpful to her based on the support they provided, and also based on their own previous experience that was similar to what she was going through.

Other participants expressed similar faith in the usefulness of seeking out the help of a priest or a nun. Magdalena, when talking about how clergy could be useful in dealing with problems in adolescence expressed:

> Well, I'm pretty sure the church has dealt with situations like that. Whether it be sex or drugs, or doing crazy stuff, I'm sure the church would be able to inform us

> as to any contact or where to go. So kind of act as a resource that would get you where you need to go. And then also to help us spiritually, too.

To Magdalena, seeking out the help of a priest was useful in a number of ways, from helping with the actual problem the adolescent may be facing based on experience in dealing with situations like that, but also in the sense that the family would gain comfort spiritually. Another participant, Maria, expressed she would find it helpful to seek the help of a priest or a nun because, "They know how to pray right. They know how to ask God to help us." To Maria, the usefulness of clergy came in the way they were able to intercede directly to God for her, which is something she felt she might not be able to do as well on her own. Similarly, Mayra expressed she believed in the power of prayer, "Because I have such great belief in God and I think that if you pray hard enough and ask enough you will, your prayers *will* be answered." In Mayra's example, it was the act of praying that she found useful, and as a result found her self relying on that for many things, including adolescent problems.

Soledad described that attending school-sponsored parenting classes was useful for her and her daughter for a number of reasons. She stated:

> It helps my daughter. She wanted me to go. It makes her feel good that I'm doing this to help her. And there's other kids from her school that go there and they go to the other room and they help the younger kids. And that makes her feel good. It's a positive thing for her. And that's probably the main reason because it makes her feel good. And also I think that the fact that there are people that work for the

> school that are there and hear what we're saying makes us feel a little more comfortable that at least we're voicing it to somebody in the school district.

In this example, the act of attending a parent class was perceived as being helpful because it made her daughter "feel good" and because it gave the mother an opportunity to make herself heard by school personnel.

Similarly, some participants expressed that they would be open to seeking a professional counselor or psychologists for their adolescent. In general, participants who were open to seeking professional help expressed they would find it useful for their child to have someone to talk to. For example, Marisol stated:

> I think having somebody to talk to is good in any situation. I think a problem that a lot of kids have is if they don't have anybody to talk to and they hold it all in and at some point in time they will explode. Be it in violence, be it in using drugs, be it alcohol, whatever the case may be.

Another participant, Sandra, expressed similar views, stating, "Well, I think I would send her to a therapist because sometimes one as a parent is not able to talk with them. I speak for myself. Sometimes we don't know how to talk to them." To Sandra, speaking to a professional might be useful in the event that the adolescent was unable to express himself or talk to his parents.

The opposite of finding a resource useful would be that the resource is *not* useful, and many participants expressed such opinions, particularly about the use of *curanderos*. Magdalena, for example, held the belief that what *curanderos* have to offer in the way of services would be useful to her and her adolescents. Magdalena stated, "To me, I think

they have nothing to do with what adolescents go through. All I know is that they deal with evil spirits or something like that. But I don't think they would be useful for anything. I mean, I wouldn't rely on a *curandero*. No." To Magdalena, a *curandero* could only help in matters related to "evil sprits," which is not something that she associates with adolescent problems. Macrina also expressed that she would not "trust" that *curanderos* would be useful because it is not something she believes in. With regard to *curanderos*, she stated:

> I'm not sure because we've never really had that faith. And I think that has a lot to do with that. Having based on the trust that these people can help. And I guess because we were not raised that way, and my boys aren't being raised that way I don't think that would be an option that we would seek.

Overall, participants had very clear notions on whether a particular resource would be useful, or not, in dealing with the problems an adolescent can face. Whether it was family, the school, professionals, or folk healers, a participant's belief in each resource's usefulness was one of the primary considerations in deciding whether to seek them.

Past experience, relationships, and involvement. Considering whether to choose a resource involves considering it through *past experience, relationships, and involvement*. Participants reported that when they had a particular experience with an entity or type of resource, it likely influenced the likelihood of them seeking out that resource again. For example, a participant who reported a negative experience with psychiatric services stated:

> Luisa: I deal with my own problems because you know I've been through everything. Doctors, psychologists, you name it. Counselors. And there hasn't been anything that can help me… I go to a psychologist, they're gonna want to put her on depression pills. That's not gonna help her… No, no.

Clearly, in this example, the participant's previous experience with doctors and psychologists had been a negative one, which led her to believe that in the future they would not be a resource she would be willing to seek. Similarly, a participant who had what she perceived as a negative experience with a *curandero* expressed she would not be willing to seek them out for problems with her adolescent. Sandra stated:

> We should take them to the doctor is what I say. Because when I was little my mom once took me to a woman who supposedly healed my head. And I remember that well. I remember the woman would press my head with a stick. And I tell my mom, "No way. I'm not taking my kids to that. No."

Others, however, expressed positive experiences that made them more likely to seek out the same resource in the future. Soledad, for example, described how a previous positive experience with a *curandero* made her feel like she would be willing to seek one out again in the future. She stated:

> My family, I have family who believe in *curanderos* and use *curanderos*. Of course you know the *ojo* (evil eye). Hey, when you've got a screaming child and

> you have somebody who comes and prays over that baby and the egg turns black and the baby feels better, well, then you know what something happened.

In this particular example, Soledad was referring to an instance in which she had used a *curandero* to help her with her own child, and as a result of that positive experience would be open to seeking one again in the future.

Another factor that contributes to deciding whether a resource will be sought out or not is the relationship that a person has with the resource or entity. Participants had various examples of how a relationship could encourage or discourage seeking out the resource being considered. Macrina provided an example of how level of involvement in the church, as well as her positive relationship with a nun and priest made her feel like she could turn to them. She reported:

> There is one nun in particular that I feel very close to that I've been working with for the past, I guess around eight years that I started… I would feel comfortable going to her. And a priest as well. I'm pretty comfortable with him. But I don't think my husband would feel as comfortable nor anyone else in the family. Again, I guess it's because I'm more involved and I work with them more and I'd feel more comfortable with them.

Similarly, participants who reported having a positive relationship with their family reported being more likely to seek out their help. Lupita, for example, reported having a very close relationship with her mother and sisters, and as a result, when she has a problem, she reported "For the most part, I call my mom, or you know, my sisters. You know, if I have a problem." Similarly, Magdalena, who reported having a very close

relationship with her mother and stepfather reported, “I count on my mom and my stepfather. Those are the people I can always, when I’m in any kind of situation, I can always count on them.”

Other participants reported that negative relationships, or lack of involvement with potential resources, would keep them from seeking those resources for a problem with their adolescent. For some participants, the fact that they did not belong to a church made them feel like it was not an option to seek the help of somebody there. When asked whether she considered the church an option with the problems she was experiencing with her daughter, Soledad stated:

> I don’t know. Probably not. Just because I’m not a member of any specific church. And a lot of churches in order to have the groups or this that and the other you have to be members of the church, and being members you have to pay so much money.

Similarly, Mayra responded that she would not be open to going to a priest or a nun because she was not aware of whom she could contact. She stated, “I don’t know. I just don’t know who to ask. I don’t really have a place that I go to, so.”

With regard to family relationships, some participants indicated that their strained family relationships made them feel they could not count on them for help. Lourdes, for example, described how she did not have a positive relationship with her family, and as a result, she reported, “I don’t think I have anyone who I can talk to,” indicating turning to her family for a problem was not an option for her. Laura reported there had been a falling out in her family that kept her from turning to her sisters if there was a problem.

Laura reported, “One of my sisters it’s been 12 years since she talked to me. She said ‘hi’ last year, but we don’t talk,” when giving an explanation for why she would not turn to her sister. Similarly, Maria would not turn to one of her sisters because they do not have a close relationship. With regard to her sister, Maria reported, “She says her hi’s and bye’s. And we’re pleasant and that’s about it,” indicating a superficial relationship that kept her from talking to her about significant problems.

Overall, participants had clear ideas of what their level of involvement or relationship with potential resources was, and used that to assess whether they would find themselves seeking those resources. When there were positive relationships or high levels of involvement with the church, participants were more likely to seek out those resources in times of need. When relationships were strained, or there was low involvement, as in with a particular church, participants reported not being willing to seek out that resource.

Other belief sets that encourage/discourage use of services. Another, more varied, intervening condition participants used in evaluating whether to seek out a resources was the consideration of *other belief sets that encourage or discourage the use of services*. Participants reported a number of thoughts or beliefs that made them feel either more or less likely to seek out a resource. These included beliefs about family, the church, professionals, and *curanderos*.

With regard to family, and why participants would not turn to them in the event of a problem, some participants expressed the concern that they did not want to worry family. Sara, for example, reported she would not call her mother saying, “Since she’s older I don’t want to worry her.” Similarly, Mercedes stated, “For my part. I don’t have a

lot of family. It's my parents and my brothers and sister. But no. I can't count on them. And I don't like, for example, my mom has diabetes. And so I do not like to take my problems to her. I don't want her to worry." Another participant reported she would not turn to her sister out of consideration for what she was going through. Leticia said about her sister, "She would probably be my last resort. She just took on two nieces and nephews, so she has a lot on her plate for me to put my burden on her. That would be too much."

Another participant reported that she would not seek out the help of her family, not necessarily out of consideration for them, but because she was the one in the family who helped others. Lourdes reported:

> I don't talk to anybody. And one of my brothers says I'm the hen mother. And who solves my problems? They just talk to me. And so they hold me up there. But I tell them I make mistakes, I have problems, and I have to hide so they don't see me because I'm the support. And that also makes me feel sick.

Lourdes' position in the family as the "hen mother," and her belief that she needed to keep her problems to herself because of the way her family views her, are what keep her from being able to count on them. Unfortunately for Lourdes, she expressed that this is not the way she wished things would be, but it was the reality with which she lives.

Other participants held religious beliefs that kept them from seeking out services of *curanderos* because they believed their use is contrary to what their church has taught them. Sara, for example, had this to say about *curanderos*:

> Sara: No, I don't believe in that. I think they are the same as us. And all they do is trick people to get money out of them. Because before I really started going to church I used to believe in that. But now that I've been going more to church I think that's all pure lies. It's not true. It's people who are just trying to trick people.

In Sara's example, she reported that prior to getting involved with the Catholic Church she would have sought the help of a *curandero.* But to Sara, what she learned by going to church "more" was cause enough to not want to seek them out. Similarly, Lupita reported that her grandmother used to believe in the use of *curanderos* when she was in Mexico, but for her, "having the faith, that strong faith, and knowing that Jesus Christ is the savior, you don't believe in those things any more."

Another participant reported that what kept her from seeking out the help of a *curandero* was the fact that she was unsure as to what their credentials might be. Maricela reported being afraid that without credentials, she did not know if she could trust one:

> I don't know if there are established *curanderos*, or if they're registered, or I don't know. So who will be held accountable? And so that scares me. If something bad happens, if I, as a hair stylist, do something bad I have my license, and I will have that to back me up. But they don't. So that scares me.

As a professional with an understanding of the purpose of credentials and certifications, Maricela was mindful of how that could affect the services she might get from someone like a *curandero*, and as a result used that in consideration of whether to seek them. In

her case, this was enough to keep her from turning to one for problems that might emerge with her adolescent children.

Although most participants articulated specific beliefs that kept them from seeking out certain resources, there were some participants who expressed certain beliefs that propelled them to seek out services despite prior negative experiences, particularly with schools. Laura, for example, reported:

> Just because I had a bad experience, I'm not going to give up… Now, I've had problems, very strong problems, with the principal here at this school to the point of being kicked out of here… And they gave up on me, but I would not give up… You figure it out along the way that there is someone to help. And when it comes to getting help for my kids, I'm not going to give up. And there are lots of us parents who give up, and when one door is shut we shut them all. I don't.

To Laura, her priority was obtaining the help that she needed for her adolescent son, and she was not willing to let prior negative experiences keep her from seeking the resources she knew were available to her in the school. Similarly, Soledad, who reported very negative experiences with the school, particularly when her daughter was sent to the alternative center, had this to say about a district-sponsored parenting class:

> Yes, there are people that work for the school district there, but I guess it's not going to affect my daughter anymore. To me it's not that it's done with people in the district. It's a parenting class. A support group. And it helps my daughter. She wanted me to go. It makes her feel good that I'm doing this to help her.

To Soledad, the fact that this resource was helpful to her and her daughter was enough reason to overlook previous negative experiences with the school district. In cases like this, the desire to help their adolescent was enough to go back to a resource they had not had positive experiences with.

In summary, there were a number of beliefs held by participants that either encouraged or discouraged the use of certain resources when it comes to problems in adolescence. Although the particular beliefs that participants held were varied, and at times idiosyncratic, what was clear was that there were definitely factors that made them feel either more or less likely to seek out a resource. Of these, the most commonly reported was the belief that the use of *curanderos* was contrary to church teachings. Many participants, however, held other beliefs based on their own experiences and motivations.

When are Resources Enough?

One important step in considering resources for when a problem arises in adolescence is to determine when a parent has sought enough resources or help to address the problem. This process was a complicated one that was many times based on individual factors, but overall was influenced by the severity of the problem, as well as signals that the problem was being resolved by the resources being used. Furthermore, when a problem was brought to the attention of the participants from the school, typically the participant found that dealing with the problem at home and through the school was enough to address the problem, based on the fact that the problem was school-based.

Some participants, for example, reported that talking to their children, or handling the problem themselves, was the only action they needed to take. In these cases, participants reported noticing a difference or a change that was significant enough to indicate the act of talking to them was enough. Selina, for example, reported that when her daughters got in trouble for fighting in school, she gave them advice on staying out of fights by ignoring what other girls were telling her. She reported that as a result of the advice, her daughters avoided further problems. She stated, "And the older one told me that the girl said to her, 'do you want to fight?' And my older one said, 'I don't want any problems.'" For Selina, giving her daughters the tools to be able to defuse a situation with other peers was enough action to deal with the problem her daughters had presented with. This approach addressing the problem at home was typically seen in families where there were problems that were not considered significant or severe.

Some participants took their cues from their adolescent's school with regard to how much intervention the adolescent needed. For example, when participants were informed that their adolescent was being sent to the alternative center, all participants reported becoming involved with the school in determining the appropriate intervention, whether the alternative center placement, or counseling. These participants, however, also reported that they felt it necessary to also talk with their adolescent about the problem and give them guidance or advice. As a result they incorporated family reliance to the steps taken to help the adolescent. Similarly, when a parent was informed that their adolescent was experiencing emotional problems that required counseling through the

school, all participants reported taking the time to incorporate talking with their children to address the emotional concern.

For other participants with more significant problems, multiple resources were sought in response to the problem or crisis. Lucia, for example, experienced a situation with her daughter where she became depressed as a result of some problems between her parents, which ultimately led to a divorce. In dealing with her daughter's problems, Lucia tried talking to her daughter, and enlisted the help of her mother for advice. She also attended a prayer group for a while to help her cope with the difficulties she was experiencing, and to ask for prayers. Lucia, however, eventually sought help through the school counselor because she felt, "The counselor could do better at talking to her. She could be more comfortable and talk about things I might not understand." Her daughter, however, continued to experience significant difficulties, including suicidal thoughts, and as a result, Lucia had to hospitalize her daughter at a local inpatient mental health hospital. Lucia's story is much like that of Luisa's who found herself taking many of the same steps, including starting with family and the school for her daughter's problems, and eventually had to seek professional help when her daughter actually attempted suicide. These two cases were perhaps the most severe in terms of problems the adolescents faced, and are the best examples of how a mother continued to seek help until she felt her daughter's problems were best addressed.

Beyond the Model

Now that we have covered in detail the model of how participants view adolescent problems and have established the steps participants have taken or would be

willing to take in helping their adolescent, it is important to consider how this process has actually been applied by the participants. In particular, it is important to get an overview of the trends that the participants have reported with regard to their use of the various resources that have been discussed, as well as their willingness to seek those resources in the future.

First, a review of some participant characteristics is warranted. Of the 27 participants, 11 had adolescents in mainstream education services, 7 were participants with an adolescent who had been placed in the alternative center for behavioral problems, and 9 participants had an adolescent receiving special education counseling services through the school district. Overall, 21 out of the 27 participants reported having had some difficulty with their adolescent, whether emotional or behavioral, as some participants in the mainstream group reported problems with their adolescents.

The age of participating mothers ranged from 31 to 55 years in the case of a participant who was raising her grandson. With regard to marital status, most of the participants were married (n=20), five were divorced, one was separated, and one was a widow. The number of children varied from 1 to 7 years, and the number of adolescents between the ages of 12 and 17 years in the households varied from 1 to 3 adolescents. Participants' occupations were varied, ranging from homemakers and housekeepers, to more professional occupations, such as a school teacher and a medical assistant, to a business owner. With regard to religious affiliation, the majority of participants (n=18) described themselves as Catholic, four considered themselves Christian, two Baptist, one Jehovah's Witness, one nondenominational Christian, and one who did not consider

herself to have any religious affiliation. There was a range in the length the family had been in the U.S., including recent immigrants who had only been in the country a total of four years, and were therefore considered 1st generation, to people who considered themselves 5th generation. As a result of some of the participants being immigrants, the language spoken varied from Spanish-speaking only, to English-speaking only, with many considering themselves bilingual to varying degrees.

Family Reliance

With regard to the use of family in dealing with a problem, also known as family reliance, there were two levels of involvement that were generally reported. The first was that of the immediate family, or parents, in helping adolescents with problems. In this study, all participants reported at least some level of parental involvement in dealing with their adolescents problems. Advice and guidance were the means through which most participants dealt with their adolescents problems. Others encouraged their adolescents to get involved in activities as a way of making themselves feel better. With regard to seeking help from other family members, such as participants' parents or siblings, 14 participants reported they had at one point sought the help of family members in dealing with adolescent problems. This included talking with other family members who had prior experience with similar problems, or simply getting their support during a difficult time. Twenty-one participants indicated they would be willing to seek out their family in the future if there was a problem with their adolescent, and 6 participants indicated they would not feel comfortable seeking out their family. The reasons cited for not wanting to

seek out family included not being close to other family members and not wanting to worry other family members.

The Church and God

The topic of spiritual faith was one that most participants spent considerable time addressing. Participants, however, made a distinction between religious figures and God, such that there were two ways in which they could count on their spiritual faith. One way was to actually seek out the help of religious figures, and the other was to use prayer or church services in times of need. First, with regard to the use of religious figures, such as priests, ministers, or nuns, only 4 out of the 27 participants reported they had actually asked for help from a religious figure in their church for a problem their adolescent was experiencing. Twenty-one participants indicated that in the future they would be interested in seeking out the services of someone in their church if there was a problem with their adolescent, and 6 reported they would not be interested in seeking out their help. Those who reported they would not be interested indicated they would not do so because priests do not deal in adolescent problems, because they would not be able to help, or because they did not belong to any particular church.

Participants also indicated their faith in the power of prayer, as well as the teachings of the church during services, were things they had turned to when there was a problem with their adolescent. Seventeen of the participants indicated they had relied heavily on prayer, which included their own prayer, as well as that of clergy and other church members. Eight participants indicated they had relied on going to church services to gain a sense of peace or hope during their adolescents' difficulties.

Schools

Schools were another resource that many of the participants had relied on, or would feel comfortable turning to for their adolescent's problems. Out of the 27 participants, 16 indicated they had at some point sought the help of their child's teacher, counselor, or principal when there was a problem. Some of the participants were involved as a result of the school informing them their child was experiencing some difficulties, whether emotional or behavioral, but some had sought the school's help on their own. Twenty-five participants indicated they would be willing to seek help through the school if a problem were to arise, and 2 participants indicated they would not. One of the two participants indicated the would not be comfortable going to the school because they had a previous negative experience in dealing with the school, and the other indicated she would not go to the school because she would rather deal with the problem herself.

Professionals

The term "professionals" here is used to describe someone who has specialized training in dealing with emotional or behavioral problems. It includes, but is not limited to, doctors, therapists, psychologists, psychiatrist, and social workers. In this study, 8 of the 27 participants had sought the help of a professional. In these cases, they included psychologists, psychiatrists, and mental health clinics. Twenty-five participants said they would be open to seeking out the help of their doctor or a psychologist if a problem were to arise with their adolescent, while 2 participants said they would not be willing to do so. One of those participants indicated she would not seek out professional help in the future

because she had a negative experience, and the other participant indicated she would not because she believed she could take care of her adolescent herself.

Traditional Folk Healers

Traditional folk healers, such as those who practice *curanderismo*, *santería*, *or hierbería*, were not a resource that any of the participants brought up spontaneously during the interviews. All participants were asked specifically if they had used or would consider the use of a *curandero,* or other folk healer, in helping with their adolescent's problems. Out of the 27 participants, none had actually ever sought the help of a *curandero,* or any other folk healer, in dealing with their adolescent's problems. Nine participants, however, indicated that in the past they had used a *curandero,* but not for helping in adolescent problems. With regard to their use in helping with adolescent problems, 3 participants indicated they would be open to seeking out the help of a folk healer in the future, and 24 participants indicated they would not be interested in doing so. The 3 participants who were open to seeking the help of a *curandero* indicated they would do it based on previous positive experiences with *curanderos*. Furthermore, it should be noted that of these 3 participants, one was an immigrant from Mexico, while the other two considered themselves 4th and 5th generation Mexican Americans who primarily spoke English. Participants who were not open to seeking the help of a *curandero* indicated a number of reasons why they would not consider their use. These included previous negative experiences with a *curandero*, the belief that they were associated with evil spirits, as well as the belief that the use of *curanderos* was contrary to their spiritual faith, whether Catholic or otherwise.

Although only 3 participants expressed interest in seeking out a *curandero* or folk healer, 7 participants indicated they use home remedies involving the use of *hierbas* or herbs. Participants reported the use of *manzanilla* (chamomile), *menta* (spearmint), and *anis* (anise) for upset stomach or to relax. They reported knowing of these remedies through their mothers or grandmothers. These participants, however, reported they brew their own teas with herbs they purchase from the supermarket, and not from a *hierbero*.

The Curandero's and Priest's Perspectives

Although interviewing a *curandero* and a priest was not a part of this study initially, after talking with the participants, it became evident participants had some very strong feelings about both of these resources that speaking to both a *curandero* and a priest became of interest to triangulate some of the information that was provided by the participants. For example, when participants reported that they would readily seek out the help of a priest, it became of interest to get a sense from a priest whether this was actually something that was occurring. Or with regard to the use of *curanderos*, when participants reported they would not find them useful for their adolescent's problems, the investigator became interested in getting an idea from a *curandero* whether they were finding the same trends in their own practice. Therefore, the *curandero* and priest were interviewed with the aim of getting support for what participants reported. While more detailed summaries of the interviews with the *curandero* and priest are found in Appendix E, for the purposes of this discussion, information presented here is limited to the two topics of interest. These include information regarding the use of each of these resources based on their experiences as a *curandero* and a priest, as well as their impressions regarding

participants' beliefs that the use of *curanderos* is contrary to their spiritual and religious faith.

With regard to the prevalence of the use of the church or religious figures, such as a Catholic priest, for dealing with adolescent problems, Father P. reported that although he and the two nuns in the parish are available during office hours, in his experience, not a lot of parents have sought his help over the years. In fact, he reported that in the last year, not a single parent had made an appointment to speak to him. He attributed this trend to his belief that members of his community have a mentality that says, "I take care of my problems, you take care of yours." Father P. reported that in theory parents may feel that he and the nuns are available, but in fact do not seek them. His report, however, may not be entirely contrary to what participants reported. Although a few did report that they had actually sought the help of a priest, most of the participants reported they would feel comfortable seeking them out.

With regard to the use of *curanderos*, Mr. C. reported that, indeed, his work with adolescents is limited to the exorcising of "entities," as when a person becomes possessed by another spirit, or for conditions such as *ojo*, or evil eye. He reported that he would not be able to help with some of the problems that were discussed with participants, such as emotional problems, academic problems, or behavioral problems, if they were not a result of a possession or evil eye. Furthermore, Mr. C. indicated that *curanderismo* is a "dying culture," because people "don't seek it anymore." In this regard, participants' overall reports that they would not seek out a *curandero* for their adolescents' problems were confirmed by Mr. C.'s reports that his work with adolescents is limited.

In the interest of better understanding participants' reluctance to seek out *curanderos,* Father P. was asked specifically what the Catholic church's position is on the use of traditional folk healers, such as *curanderos*. While participants had reported that they would not seek out a *curandero* because they were contrary to what the church taught, or because they dealt in witchcraft or evil spirits, Father P. had a different perspective, which is the official stance handed down by the Vatican. Father P. reported that the use of *curanderos* was not contrary to the church's teachings provided a *curandero* does not do anything that could be considered "anti-Christian." In fact, Father P. believes there are healers who are "Simply people who pray for other people. Who use herbal remedies." He believes there is nothing wrong with the use of such healers. Given what the participants were reporting, however, Father P. had this to offer as an explanation: "*Curanderos* have a reputation. People are afraid. They think they're all atheists. I don't know where that [belief] came from."

When informed about some of the beliefs the participants had shared, Mr. C. was not surprised, but stated that those who believe *curanderos* are associated with witchcraft or evil spirits are "Ignorant people who don't do research." He firmly believed there is a misunderstanding between what he really does and what people believe. For example, Mr. C. made a distinction between working in the "light" and in the "dark," or working with good versus evil spirits. He stated that he only works in the light, but that many people believe all *curanderos* deal with evil spirits. He also stated he believed a lot of the mistrust that people have towards *curanderos* is due to the fact that there are "charlatans" who use "trickery" to steal from people.

Overall, some useful information was gleaned from the interviews with the *curandero* and priest. First, while participants may feel they would be comfortable seeking help from religious figures such as priests or nuns, it appears that in practice, this is not actually occurring, as experienced by one Catholic priest. Second, although many participants, Catholic or otherwise, reported their religious or spiritual beliefs kept them from seeking out the services of a *curandero*, it appears that at least the Catholic church does not specifically condemn the use of *curanderos*, provided they heal in a manner that is consistent with Christian beliefs. One thing that participants and the *curandero* did agree upon is the fact that today, at the very least in central Texas, there is a low incidence of the use of *curanderos* for problems such as those that have been discussed in this study.

Chapter Summary

The results of this study, presented in this chapter, have shown a complex process that Mexican American mothers and families go through in facing problems in adolescence. Participants in this study have informed us that as parents, they are able to make judgments on when an adolescent is healthy and when an adolescent is facing a problem. Healthy adolescents are those who are happy, do well in school, and face little or no problems. Their well-being is attributed to having loving and supporting families in which the parents lead by example, communicate with their children, encourage activities, and are generally involved with them. Participants believed, however, that adolescents can also have problems that range from emotional to behavioral, and these can be seen at home and at school. Participants also indicated their beliefs that adolescent

problems can occur as a result of negative factors such as peer pressure, parent and family problems, academic stress, the presence of gangs, and prejudice they face as Mexican Americans. Overall, participants had beliefs about adolescent health and problems that closely mirrors some of the literature that was presented, and will be discussed further in the next chapter.

With regard to seeking help for their adolescent's problems, participants indicated they first determine whether there is actually a problem that needs addressing. Participants indicated that they determine there is a problem based on behaviors and changes they notice in their adolescent at home, or based on reports from school. This sets off a process of *evaluating resources in response to adolescent problems*, which is the model that was presented as a result of this study. After determining that the adolescent has a problem, the process began by selecting from a "menu" of options that the mother considered to be available to her, at times selecting multiple options. Upon making a selection, or selections, from the available resources, the participant engaged in a process of evaluating each resource via a particular set of intervening conditions, which helped the mother decide whether to pursue the resource she was evaluating. At that point, the mother determined whether a selected option was enough, or whether other options needed to be considered. This process continued until the mother determined the adolescent's problem had been resolved.

Upon exploring the complex processes that participants engaged in when their adolescent demonstrated some difficulty, it important to consider how its application affected the resources the participants actually sought out or would be willing to seek out.

Although not a quantitative study, an important aspect of this research was exploring the trends participants were reporting. Overall, there were strong indications that family reliance, churches, schools, and professionals were some of the resources participants would consider in helping their adolescents. The reported trends of use or likelihood of use are as follows: 14 participants had relied on family for adolescent problems, and 21 felt they would consider them in the future; 4 had turned to their church, and 21 would consider it in the future; 16 had been involved with the school to help their adolescent, and 25 would consider it in the future; and 8 had turned to professional mental health providers, and 25 would consider that option in the future. The use of traditional folk healers, such as *curanderos*, however, was not indicated as a resource participants would consider. None of the participants had actually ever sought the help of a *curandero* or other folk healer for their adolescent's problems, and only 3 would be willing to consider it an option. The other 24 participants indicated they would not be interested in seeking the help of a *curandero* because they believed it would not be helpful, and because they believed *curanderismo* to be associated with evil spirits, which they perceived to be contrary to their spiritual faith.

The perceptions of a *curandero* and a priest were then sought to gain a better understanding of what the participants had reported. In general, the *curandero* indicated that there were not many parents seeking out his services for the types of adolescent problems that were discussed by the participants, giving support to participants' reports. With regard to the use of religious figures, although the majority of the participants indicated they would be willing to seek out the help of someone in their church, the priest

indicated that, in actuality, families were not seeking out his help or that of the church. Furthermore, he indicated that the church does not, in fact, discourage the use of *curanderos,* provided they are not acting in a manner that is contrary to Christian teachings. In this respect, it would seem participants should feel free to seek the services of a *curandero*, but in fact they do not as a result of their perception of them being associated with evil spirits, which the *curandero* reported stems from participants lack of knowledge with regard to what a *curandero* actually does.

In the end, the results of this study indicated that the Mexican American mothers who participated were attuned to adolescent functioning, with a keen sense for determining whether their adolescent is experiencing problems. These participants were able to navigate a complex system that involved considering other resources in their surroundings to address their adolescent's problems. Overall, participants indicated positive regard toward the use of family, church, schools, and professionals in helping their adolescent, while the use of traditional folk healers, such as *curanderos*, was not indicated.

CHAPTER 6: Discussion

This chapter discusses the implications of the model that emerged as part of this qualitative study. First, the literature is briefly reviewed again, comparing the results of this study with the findings of previous research on Mexican American families, adolescent problems, and use of resources, including alternatives to mainstream mental health services. This is followed by a discussion on the implications of the model for practice and research.

Discussion of Results and Integration with the Literature

In grounded theory research, the literature reviewed before the collection of data is set aside during the research process. This allows for a theoretical model to be built upon the ideas and concepts that emerge from the data itself, rather than forcing the data into categories established before the research (Glaser, 1978). Upon creating a model, however, it is important to return to the literature reviewed and determine how it compares with the current findings.

With this is mind, let us begin with a review of the relevant literature as it relates to the results of this research. This includes a review Mexican American parents' beliefs about adolescent problems, as well as utilization of mental health services and alternatives for Mexican American adolescent problems.

Mexican American Parents' Beliefs About Adolescent Mental Health

Bui and Takeuchi (1992) recognized that there is a need for community studies of ethnic minority youth to document help-seeking behaviors. They also noted that parent attitudes and beliefs about mental health could be a barrier in help-seeking. However,

little research, however, has been carried out to examine Mexican American parents' beliefs about mental health and attitudes toward treatment, and that which has been conducted has focused on parents who have already sought treatment (McCabe, 2002; Yeh et al., 2005), and completely overlook attitudes and beliefs of those who do not seek treatment.

First, we turn to Mexican American parents' beliefs about adolescent mental health problems. In this study, Mexican American mothers demonstrated insight into the types of challenges adolescents today face, and the problems those challenges lead to. Participant reports of adolescent problems closely corresponded to those that were discussed in the literature review. As reviewed previously, early signs of problems in Mexican American youth include school failure and police records, which are disproportionately high in this population (Organista, 2003). These early signs are later seen in higher school dropout rates (Rumberger, 1998; Rumberger & Larson, 1994), risky sexual behaviors (Baumeister, Flores, & Marin Van Oss, 1995; Berry, Shillington, Peak, & Hohman, 2000), substance abuse (Center for Disease Control and Prevention, 2002, 2006), delinquency (Poe-Yamagata & Jones, 2000), depression and high suicide rates (Roberts, Roberts, & Chen, 1997).

As was discussed in the results section, participants in this study reported problems in adolescence, including emotional problems such as sadness and depression, as well as gang involvement, drug use, sex, and some reports of suicide attempts. While academic problems were mentioned in terms of stressors adolescents face, the problem of school dropout rates was not mentioned by any of the participants. It is possible that this

is not a problem that had been encountered by the participants, given that most had adolescents who had not reached that point in their education. Furthermore, the demographics of this school district indicated dropout rates were not disproportionately high compared to the rest of the state, and as such this may not be an issue that is prominent in the community or among parents. Overall, however, it appears that in this study sample, participants have a realistic view of the types of problems adolescents today face.

Another important thing to consider is parents' beliefs about what contributes to adolescent problems. Our current understanding of children's mental health, as well as their problems, is based on the assumption that a multitude of factors interact to produce these outcomes. While a number of investigators have developed various guiding principles, by and large, it is accepted that childhood psychopathology arises from the interaction between individual factors and the environmental factors (Cicchetti & Cohen, 1995; Jensen, 1998; Sroufe & Rutter, 1984). Individual factors include biological and genetic factors, while environmental factors can include family and peer relations, community factors, and the larger social context. The ways these factors interact contribute to unique outcomes for each individual child. In this study, participants demonstrated an understanding that adolescent problems do not occur in a vacuum, but rather in a context of factors that contribute to their development. In particular, participants in this study noted the effect of peer pressure, the presence of gangs, academic stress, prejudice, and family problems as factors that contribute to adolescent problems. It is interesting to note, however, that none of the participants reported

biological factors as contributors to adolescent problems. Instead, the focus by and large was on external or environmental factors. It is possible that lower levels of educational attainment amongst participants, and a lack of familiarity with medical models of mental health problems, accounts for their absence in participant explanation. Furthermore, external or environmental factors are easier to see and experience than biological or medical factors, and as such may be more prominent in participants' awareness. Understanding beliefs about the types of problems adolescents face and the factors that contribute is important because it can give insight as to the types of resources parents are likely to turn to when a problem arises. For example, in this study, when participants believed their adolescent was experiencing school-related problems, or problems that had roots in the school environment, including peer problems, mothers were more likely to seek out help from the school. When participants found problems that were emotional in nature, they sought the help of psychologists or psychiatrists, in addition to family reliance. As none of the participants reported that adolescent problems had a basis in supernatural forces, it is likely this is why the use of *curanderos* or folk healers was not reported. Interestingly, although none of the participants reported a spiritual basis for adolescent problems, there were numerous reports on the use of prayer, and reports that participants would be open to seeking out the help of religious figures. This could indicate that spiritual faith and religion are such a prominent part of participants' lives that it is a source they turn to regardless of whether that is the source of the problem, and it serves a function, as reported by participants, of providing comfort, that may not

necessarily be related to the resolution of the problem, but rather the coping of the problem.

With this information in mind, let us now turn to previous research on mental health service use by Mexican American youth, and the results of this study as they relate to the use of different resources when adolescent problems arise.

Utilization of Mental Health Services by Mexican American Youth

Minority children show patterns of utilization different from that of White children. This mirrors patterns of utilization by adults as found by a number of researchers discussed previously (Casas, 1984; Echeverry, 1997; Padgett et al., 1994a; Sue, Zane, & Young, 1994; Treviño & Moss, 1984). A study by Bui and Takeuchi (1992) examined rates of utilization and treatment dropout of African Americans, Asian Americans, Hispanics, and Whites, finding that Mexican Americans were underrepresented in using mental health services. A more recent study by Yeh and colleagues (2005) found that Latino youth were less likely than non-Hispanic Whites to use mental health services even when controlling for demographic variables and severity of symptoms. Latino youth are also more likely to terminate early, with as many as 60% to 75% dropping out after the first treatment session (McCabe et al., 1999).

While this study did not examine termination patterns, as this was not a group of participants selected because of the services they were receiving, it did examine the use of mainstream mental health services. In this study, 8 of the 27 participants had sought the help of a professional. In these cases, they included psychologists, psychiatrists, and mental health clinics. Although not a quantitative study, it would appear that the fact that

30% of participants reported the use of some type of mental health professional is not insignificant. It is difficult, however, to truly quantify and make generalizations based on the limited information, and the fact that the only information provided was parent reports. While not all participants in this study had experienced a problem that would necessarily merit the use of professional help, it is interesting to note that an overwhelming majority indicated they would be open to the concept. That is, 25 participants said they would be open to seeking out the help of their doctor or a psychologist if a problem were to arise with their adolescent, while two participants said they would not be willing to do so.

While the numbers of participants who had previously sought out professional mental health services was relatively limited, there were other resources that participants reported using to help with their adolescent problems. In particular, these included the use of family and religious figures or the church. This leads to the discussion on the alternative resource theory that was discussed in the literature review.

Alternative Resource Theory

Because beliefs in the spiritual, family reliance, and shame have been linked to Mexican American's underutilization of mental health services, as well as their use of alternatives, researchers have developed an "alternative resource theory" (Leong et al., 1995, p. 426). This theory is based on an assumption that Latinos come from a culture that makes use of different methods of treatment to address psychological problems (Woodward et al., 1992), including family, friends, folk healers, or religious leaders (Flaskerud, 1986; Keefe, Padilla, & Carlos, 1976). The alternative resource theory has

received support from research that has shown use of these alternative resources (Alvidrez, 1999; Guendelman & Schwalbe, 1986; Leslie & Leitch, 1989). It is believed these alternatives continue to be sought because they provide some relief to people during times of distress. Researchers found that among Latinos with similar levels of stressful life events, the likelihood of psychological distress and subsequent use of mental health services decreased as use of social support increased (Goodman, Sewell, & Jampol, 1984). In this study, the use or consideration of family, religious leaders and folk healers was examined, and will be discussed now.

Family Reliance. Within the Mexican American community, families have long been known to be a valuable resource when someone is suffering from stress, emotional problems, or maladaptive behavior (Harris et al., 2004). In a classic study of Mexican Americans in South Texas, Jaco (1959) found that families tended to provide significant support to other members in their times of need, including during times of psychological distress. He found that one key role the family can play is in providing comfort, support, and love to the person suffering. Other researchers have also found that Mexican Americans believe mental health problems are best taken care of within the family (Edgerton & Karno, 1971). In a more recent study, Alvidrez (1999) also found that Latinas were more likely than African American and White women to believe psychological problems should be talked about only within the family. This has been corroborated in studies that show Mexican Americans are more likely to rely on family support than turn to mental health professionals when experiencing distress (Echeverry, 1997; Leong, 1995). Furthermore, Briones and colleagues (1990) have found that

Mexican Americans who report using family as support show reduced levels of depression.

In the present study, there was strong support for the use of family in times of distress. In particular, 14 participants reported they had at one point sought the help of family members in dealing with adolescent problems. This included talking with other members of the family who had prior experience with similar problems, or simply getting their support during a difficult time. Of the total, 21 participants indicated they would be willing to seek out their family in the future if there was a problem with their adolescent, and 6 participants indicated they would not feel comfortable seeking out their family. As in the literature reviewed, the participants who had sought out the help of family indicated they found them useful in providing support, but also in providing advice in dealing with the problem.

Beliefs in the Spiritual and God. Mexican Americans are believed to have strong connections to the spiritual, religion, and God. It has been estimated that nearly 90% of Mexican Americans have strong Catholic roots (Falicov, 1996). This is particularly important when dealing with traditional Mexican Americans and their mental health problems because there is a strong tendency for disabilities to be viewed as supernatural in origin, or to be interpreted as divine punishment for sin (Smart & Smart, 1991). God is considered a central part in the cause of suffering (Koss-Chioino, 2000). Surprisingly, in this study there was no support for this phenomenon, with none of the participants in this study indicating that perhaps an adolescent could suffer from a problem that has supernatural origin, or is a result of divine punishment. Interestingly, despite this finding,

participants had a strong reliance on their spiritual faith, as well as in their religion. Participants indicated their faith in the power of prayer, as well as the teachings of the church during services, were things they had turned to when there was a problem with their adolescent. Seventeen of the participants indicated they had relied heavily on prayer, which included their own prayer, as well as that of clergy and other church members. Eight participants indicated they had relied on going to church services to gain a sense of peace or hope during their adolescents' difficulties.

Traditional Folk Healing Approaches. In reviewing some of the literature on the use of folk healers, it was noted that very little epidemiological data are available on the utilization of folk-based treatment by Mexican Americans, particularly for adolescent problems. Some studies have reported the use of *curanderos* by a small percentage of Mexican Americans in California (Chavez, 1984; Gilbert, 1980; Keefe, 1981). Their studies, however, did not tap into a representative sample of the population. Some reports have indicated utilization rates as high as 54%. In a survey of 128 Hispanic American women in Colorado, Rivera (1988) found that 20% of all women had visited a *curandero*, and that 1 out of every 8 (13%) had taken their child to a *curandero* for treatment of illnesses. This mirrors previous research from Rivera and colleagues (1986), and Kay (1977), who also found Hispanic women were likely to have indigenous beliefs. In a more recent study, Sleath and Williams (2004) examined the relation between Hispanic ethnicity and patient use of alternative treatments for depression. Of the 141 participants, 36% reported talking with a religious person, 17% used herbal remedies, and 5% had seen a *curandero.* Although there were no studies found on the use of *curanderos* for

treatment of adolescent emotional or behavioral problems, it could be assumed that their use for such purposes would be similar to their use for adults and children, but this is difficult to determine without actual research focusing on adolescents in particular.

While scholars acknowledge the continued study of *curanderismo* (see Harris, 1998; Harris et al., 2004), newer research has not focused on utilization, but rather on ways to incorporate indigenous beliefs into therapy. Citing classic studies, such as those of Jaco (1959) and Kay (1977), researchers today acknowledge the relevance of folk healing beliefs of Mexican Americans, without providing evidence of its continued use or endorsement by the community. This is also true for their use specifically for adolescent problems.

In this study, however, there was minimal support for the use of *curanderos* for adolescent problems, as none of the participants indicated they had ever sought the help of a *curandero* to help with their adolescent's problems. While 9 participants indicated they had used a *curandero* at some point, most notably to deal with health problems of a baby or toddler, 24 of the 27 participants indicated they would not be open to seeking out the services of a *curandero* or other folk healer for adolescent problems. Only 3 participants indicated they would be open to seeking out the services of a *curandero* based on previous positive experiences. None of the participants, however, named a *curandero* on their own as a possible resource, but rather only considered it as a result of the investigator asking about it directly. Furthermore, although two participants indicated they did believe in *el ojo*, or evil eye, they did not mention this in the context of the types of adolescent problems they had reported, but rather in the context of past experiences

where children cried with no other known problem. Aside from those instances, there were no other reports of adolescents or children suffering due to supernatural forces or from divine punishment. Overall, the results of this study do not fall in line with previous research, as I explain below.

One of the unique aspects of this study is that participants were asked explicitly to articulate their beliefs on the use of various resources, including the use of folk healers such as *curanderos.* As a result we have some insight as to what Mexican American mothers are thinking with regard to the use of *curanderos*, and specifically about their use for adolescent problems. In this study, participants who were not open to seeking the help of a *curandero* indicated a number of reasons why they would not consider their use. These included previous negative experiences with a *curandero*, the belief that they were associated with evil spirits, as well as the belief that the use of *curanderos* was contrary to their spiritual faith, whether Catholic or otherwise. This is important to note because it brings us closer to understanding the things that Mexican Americans value, specifically when considering what resources to seek for their adolescent. For this sample, it was clear that the use of traditional folk healers was not something that was valued by the overall sample.

Implications of the Model

The model that was developed as a result of this study has the potential for direct implications in providing services to Mexican American adolescents and their families, whether in a clinical setting or in a school setting. The model offers provides an understanding of the complex thought processes that a family has already gone through

up until the point they decide to seek out services, and provides insight into the beliefs a parent may hold as they seek help. It also outlines a framework from which a practitioner may work that can include consideration of other belief sets, such as spiritual faith or reliance on family, which may come to be important in working with clients, including the adolescent and the parent.

As it was presented in chapter 5, the model developed as a result of this study is one that depicts the processes Mexican American mothers and families go through in determining if their adolescent had a problem that requires help, and the steps they take in determining what resources to seek out. The framework incorporates specific thoughts and beliefs about the resources available, and the factors that encourage or discourage their use, in a dynamic manner, which has a direct impact on their ways of responding their adolescent problems.

Evaluation of Adolescent Health and Problems

As discussed previously in this chapter, participants in this study had very insightful information with regard to the differences between healthy adolescents and those with problems, and they mirrored the information the literature reflects. This information gives us insight into the fact that parents are aware of the types of problems adolescents are facing, which is important because the types of problems adolescents face can inform the type of intervention parents seek out. It is heartening to see that parents are attuned to the fact that external or environmental factors can have an effect on adolescents. However, the fact that participants did not think of biological factors as potential contributors to adolescent problems can have implications for practitioners in

that it may be challenging to convince, or "inform", parents that interventions aimed at addressing those biological factors could be beneficial, potentially making it more difficult to work with these families in an effective manner.

Determining if Adolescents Need Help

One of the unique aspects of this study is the notion of determining whether an adolescent needs help. For the first time, participants were asked to describe the process they go through in evaluating and determining whether an adolescent's problem merits seeking help. In this study, participants reported a number of ways in which they determined their child needed help. One of the ways that was most commonly reported, particularly by participants whose adolescent was receiving counseling services or had been placed at the alternative center, was through school contact. Other parents reported that they noticed a change in their adolescent. In most cases, some of these occurred simultaneously, as when parents noticed a change in their adolescent and were also informed by their school that there was a problem. This aspect of the study is interesting in that it gives insight into the signals parents are identifying, and the thresholds they are considering, in deciding whether to seek help. Future studies could focus on developing this area of research by asking more specific question regarding the signals parents notice or focus on when determining whether their adolescent child might need help, as it is important to understand what parents are looking at when determining what resources to seek. Furthermore, this area of research could help inform where the gaps are in what parents are noticing about their adolescents, and help educate the parents on the types of signals to look for in an adolescent who may need help.

Menu of Options Available to Mothers in Helping with Adolescent Problems

This part of the model focused on the resources that participants considered to be options in helping their adolescent with problems. In the literature review, we reviewed the resources that are available to Mexican American families, which included alternative resources as well as mainstream mental health services. A mother's first step in obtaining help for their adolescent is to determine what resources are available. In this study, participants were asked first to state, in a broad sense, what they believed was available to them. The responses were surprisingly uniform, with participants consistently reporting they were aware of the use of family, religious figures, their adolescent's school, and other professionals in obtaining help for dealing with adolescent problems. This finding is important because it gives us an indication that mothers are aware of the broad types of resources that are available, regardless of whether they would actually use them, and results show that lack of information of what is available does not appear to be a barrier to obtaining help for adolescent problems.

Which Resource to Consider First?

Despite the fact that participants are aware of a number of different resources that are available to them, those resources were not necessarily considered simultaneously. Rather, it appeared that participants had a system for determining which resource they would be most likely to consider first. For the majority of the participants, there were "layers" of resources such that they were more likely to seek out the resources closer and most accessible to the core family, and later consider other, more distant, resources. The

concept of "layers" is borrowed from Bronfenbrenner's (1990) ecological systems theory, in which there is a "structure" to the environment in which a child develops. In this study, participants reported a sense of having these "layers," with the core family at the center of the system, and extending outward to parents' family of origin, followed by religious entities, such as churches, to the adolescents schools, and finally to "professionals" and outside agencies. This is an interesting finding that gives insight as to how Mexican American families might be viewing themselves in the greater societal and environmental context. It also provides support for past research that indicated there is a strong reliance on family amongst the Mexican American community. The interested researcher could focus more on this area, and could look into more specific perceptions, beliefs, and values that contribute to the layout of this particular structure for Mexican American families, and what maintains this particular layout. It would also be interesting to explore the possibility that this structure may be different in other areas in the country, or whether there is consistency regardless of geographical setting. Furthermore, it might be of interest to compare a structure like this to other ethnicities to determine if this phenomenon is truly unique to this population, or whether other groups have similar systems in place.

Evaluating Resources: To Seek or Not to Seek?

The decision to seek or not seek resources in response to adolescent problems is perhaps the most crucial aspect of the model, in that the likelihood of an adolescent getting healthier hinges on the decisions her parents make. The literature reviewed covered a number of factors that have been postulated to affect help-seeking, including

demographic characteristics (e.g., gender, educational attainment, and legal status), cultural factors (e.g., religious beliefs, acculturation, and English proficiency), as well as organizational variables (e.g., location and cost of services; personnel language) (Briones et al., 1990; Echeverry, 1997; Leong et al., 1995; Woodward et al., 1992). In practice, studies have shown that Latino youth were less likely than non-Hispanic Whites to use mental health services even when controlling for demographic variables and severity of symptoms (Yeh, 2005), and are generally underrepresented in the use of mental health services (Bui & Takeuchi, 1992).

In this study, the researcher was not looking specifically at factors such as legal status, educational attainment, acculturation, or language. Some of these data, such as educational attainment, length of time in the country, and language, were gathered not for comparative purposes, but rather for descriptive ones. Based on the participants' responses, however, it appears that educational attainment, acculturation, nor language played a significant role in participants' decision to seek out professional mental health services. That is, of those who had turned to professional for help with there adolescent, there were a mix of educational levels, as well as in the generation the participant was in this country, and some were primarily Spanish-speaking. Again, while this is not a quantitative study that could show comparisons and statistical significance, it does, however, begin to give evidence that perhaps these factors do not play as large a role as previously believed, although this is an area that needs to be specifically addressed in future research. These factors, however, are important to study further, and future

research should focus on examining these more closely to determine whether they continue to play an important part in help-seeking behaviors.

Furthermore, the literature reviewed indicated organizational factors, such as location, cost, or personnel language could be barriers to seeking professional services. Participants in this study, however, did not indicate that any of these factors had an impact in their decision to seek out services, or their likelihood to consider them in the future. Similarly, in the literature review we saw that researchers have found evidence that mental illness has a stigmatic connotation attached to it within the Mexican American community, and that these stigmas have been linked to underutilization of mental health services (Malgady, Rogler, & Constantino, 1988), but in this study there was no evidence of that. Although the participants were not asked explicitly about stigmatic attitudes, it is interesting that there were no reports that hinted at this. It is possible that the self-selection of mothers who participated in the study accounts for this, as it is likely that if a mother agreed to speak with a researcher in the field of psychology, they, at minimum, had a respect for the field. Similarly, it is possible that those who self-selected out of the study are those who perhaps did hold stigmatic views about psychology or other professional mental health fields. Regardless, future research could focus more explicitly on studying how organizational factors or stigmatic views are, or are not, continuing to be barriers to seeking professional mental health services for Mexican American adolescents.

When are Resources Enough?

Another aspect of the model focused on when participants decided they had sought enough resources to address the problem, or when the problem had been successfully resolved. This process was a complicated one that was many times based on individual factors, but overall was influenced by the severity of the problem, as well as signals that the problem was being resolved by the resources being used. Some participants took their cues from their adolescent's school with regard to how much intervention the adolescent needed. For other participants with more significant problems, multiple resources were sought in response to the problem or crisis. Although this study provides a good starting point to understanding this process, there needs to be more research in this area, particularly because with regard to the use of professional mental health services, Latino youth are more likely to terminate early, with as many as 60% to 75% dropping out after the first treatment session (McCabe et al., 1999).

In addition to the limitations and implications discussed with regard to the specific areas of the model, it is important to consider other aspects of the study that merit attention. One limitation of this study concerns the confidence with which results of the exploratory analyses concerning Mexican American mother's beliefs and resource use can be generalized. Although information pertaining to demographic categorization (e.g., Mexican American) was collected based on participant reports, participants were limited to those who lived in the particular geographic location where the school district was located. Again, this was in a small, rural community in the southwestern United States with a large population of Mexican American families. These families, however, are not

considered representative of all Mexican American families across the nation, and as such, generalizations should be cautioned against. Had the sample of participants been more inclusive of Mexican American families across the U.S., the results could be interpreted and generalized with greater confidence. As such, a recommendation for future research would be to draw from a sample that is more inclusive. An extension of this recommendation would be to consider comparing Mexican Americans who are living in the U.S. to a population in Mexico to compare and contrast their beliefs and practices, and determine where similarities and differences lie. This could provide information regarding what it is about the culture or context in the U.S. that could account for any differences between both groups.

Concluding Remarks

Overall, the model that was developed gives us a picture of the complex processes that families can go through in seeking resources in dealing with adolescent problems. It has shown us that the processes are not as simple as deciding "yes" or "no" with regard to the use of a particular resource, but rather is a complicated process that incorporates many different beliefs and attitudes about mental health, as well as the resources that are available. The likelihood of seeking a resource for adolescent problems is a function of beliefs about its usefulness, as well as about the relationships between families and those resources, and is affected by previous experiences and other factors that encourage or discourage their use. The participants' responses in this study gave corroborative support for previous research, specifically in to the alternate resource theory, in that Mexican American families, indeed, indicated the use of alternative resources such as family and

the church. This study, however, also began to indicate what is perhaps change in the Mexican American community, and that was the indication that there is perhaps not much reliance of traditional folk healers, like previously thought. Although this is a qualitative study that only begins to "scratch the surface," it provides some new insights that helps inform future research.

Perhaps, the most important implication of this study is that, as practitioners and researchers, we need to be sensitive to the thoughts and beliefs that lead a parent to take the steps they have chosen in helping their adolescent. This means being able to have the ability to respect those things that may stand in contrast to what the practitioner believes. It also means incorporating those aspects of their belief systems that are complimentary to the treatment plan developed for their child. Equally important is the recognition that today's Mexican American family is not necessarily like traditional Mexican American families in the past, and as times and families change, our conceptualization of them needs to move in the direction they take us in order to better understand and serve them.

Appendix A: Invitation Letter to Participants

Dear Ms. Participant:

You are invited to participate in a study to learn more about how Mexican American mothers of adolescents (ages 12 to 17 years) feel and think about various aspects of their adolescent's mental health. My name is Lucila Ramírez Pate, and this research is being carried out as part of my requirements as a doctoral student in Educational Psychology at the University of Texas at Austin.

If you choose to participate in this study, I would like to interview you because I believe your ideas and thoughts will help me better understand how mothers deal with emotional and behavioral problems that may come up with their adolescent. During this interview I would ask you a variety of questions. These may include questions about your beliefs about the types of problems adolescents face, what you might do to address these problems, how your actions for your child may differ from what you would do for yourself, as well as your beliefs about the types of services that are available to your child. Approximately 30 individuals will participate in this study.

The interview would last for approximately an hour, and it would be conducted in a private setting, such as your home, or in an office in one of the schools. The interview will be tape-recorded so that I can later go back and transcribe it to better understand what you told me. If any part of the interview is used in a document in the future, I will not include any information that could identify you.

This study has been approved by my dissertation chairs, Deborah Tharinger, Ph.D., and Richard Valencia, Ph.D., as well as by the Department Review Committee concerning human subjects. The potential benefits to you for participating in this study are that you might enjoy talking about your thoughts and feelings about these topics. It is possible, however, that talking about these topics may be upsetting to you. If at any point in the study you wish to stop participating, it is your right to do so with no consequence. Your decision to not participate or discontinue participation will not prejudice your future relations with the University of Texas or any faculty members.

If you have any questions or concerns about this study, please contact me at (512) 996-0106. You may also contact Dr. Deborah Tharinger at (512) 471-0283 or Dr. Richard Valencia at (512) 471-0378.

Thank you for your participation. Attached you will find a consent form I would like for you to return in the self-addressed, stamped envelope indicating whether you are interested in participating. You may keep this cover letter, as well as a copy of the consent form, for your records.

Lucila Ramírez Pate
Doctoral Student in School Psychology
The University of Texas at Austin

Appendix B: Consent Letter

Dear Participant:

Please fill this form out and return it in the enclosed self-addressed, stamped envelope to:

Lucila Ramírez Pate
1 University Station D5800
Austin, TX 78712

Name:_____

Address:_____

_____

Phone number:_____

Email:_____

Best time and method to contact:_____

Age/s of child/ren:_____

Are you Mexican/Mexican American/Chicano/of Mexican descent (circle): YES NO

Please check one:

_____ **YES**, I would like to participate in the interview and it is okay to contact me about my participation in this project.

_____ **NO**, I am not interested in participating in the interview.

_____ _____

Signature of Participant Date

Appendix C: Interview Guide

Subject #_____ Date_____

I would like to talk with you to get to know your thoughts about a number of things. I am going to ask you different questions about your child and your thoughts on the types of problems children his/her age can have. I'm also going to ask some personal questions about you. I want you to feel comfortable, so I only want you to answer with what you feel comfortable sharing.

Demographics	**Family**
• Age • Work: self, spouse (if applicable)- how long together? • Education • Speak English or Spanish? Child? • Length family in U.S?	• Family history: tell me about your family. • Do you consider yourselves "close" • Members? • Extended family? *Compadres, padrinos, etc.* • Who do you "count on"? • Turn to in times of need?
Religious/spiritual background	**Perceptions of adolescent problems**
• Tell me about your spiritual faith • Religion? • Involvement? Practice? • What does it mean to you? • Use in helping with problems? How?	• Meaning of growing up healthy? Family's role/responsibilities? • Problems adolescents (12-17) face? • Behavioral? • Emotional? • School? • Differences in boys and girls?

Help-Seeking: Child	**Help-seeking: Self**
• Your child: Any problems we've discussed? • What did it look like? • What happened? What did you do? How did it help? • If no: know a child who did have problem? • What did that look like? • If something came up with your child? • What would you do? Who turn to? What makes you think that would be helpful?	• Did you ever experience emotional problems? • What did it look like? • What happened? What did you do? How did it help? • If no: know someone who did? • What did that look like? • If something came up for you? • What would you do? Who turn to? What makes you think that would be helpful?
Services available: Beliefs	**Use of alternatives**
• What is available for your child? • Doctors? • School: counselor? Teacher? • Have you used these? • What did it look like? • How do you feel about each? • Know others who have?	• Knowledge of use of *curanderos* for these problems? • *Hierbero?* How? • Religious figures? How? • Family? How? • Others? How? • What does it look like?

Appendix D: List of Resources Available to Participants

CRISIS INTERVENTION

Facility Name	Address & Phone Number	Services/Description
Travis County MHMR	1430 Collier Street Austin, Texas, 78704 (512) 447-4141 8am-5pm (SPOE): 472-HELP (4357) 512.472.4357 (intake appt)	Behavioral Health, Child & Family Services, Crisis Services, Developmental Disabilities, Housing, Support/Educational Groups, Supported Employment
Austin Child Guidance Center	810 W. 45th St. Austin, Texas 78751 512.451.2242 Website: austinchildguidance.org Hours: Mon-Thurs 8a-8p Friday 8a-6p	Comprehensive evaluation for children including: psychiatric services, neurological testing, speech and hearing assessment, counseling for physically and sexually abused children. Individual, group, and family therapy, parent education classes, information and referrals. Medicaid, CHIP, and sliding scale fee.
APD	311 512.974.5000	Non-emergency report line for citizens looking to report illegal activities or concerns, but not in need of immediate emergency assistance.
Austin Police Department (Child Abuse Unit) **Victim Services**	715 E. 8th St. Austin, Texas 78701 512.834.3890 512.974.5037	Crisis intervention, advocacy, counseling, domestic violence, and other crime victims. Bilingual services available.
CASA of Travis County, Inc.	6330 Hwy. 290 E., Suite 350 Austin, Texas 78723 512.459.2272 Website: casatravis.org	Court appointed special advocates for cases of child abuse and/or neglect
CAPE Team	Austin/Travis County MHMR Center 56 East Avenue Austin, TX 78701 512-804-3000 OR 448-0185	Child & Adolescent Psychiatric Emergency Team
Center for Child Protection	1110 E. 32nd St. Austin, Texas 78722	Crisis counseling for child victims. Siblings and non-

	512.472.1164 Website: centerforchildprotection.org	offending parents to deal w/ sexual and physical abuse and the immediate crisis of the abuse and investigation.
Child Protective Services	1-800-252-5400	For Child Abuse Reports & Help
Children's Services	6207 Sheridan Ave. #200 Austin, Texas 78723 For appointments: 512.472.HELP (4357) 512.448.0187 Website: atcmhmr.com Hours: Tue and Thurs 8a-7p	Sexual abuse support groups. Juvenile sex offenders' treatment. Parenting classes, individual and group therapy. Fees are sliding scale. Also accepts Medicaid, private insurance, and CHIP.
Family Crisis Center	431 Old Austin Hwy. Bastrop, Texas 78602 512.303.7755 Website: family-crisis-center.org	Offers legal advocacy and referrals for victims of family violence, sexual assault and/or child abuse, also offers parenting classes. Emergency shelter for abused. Covers four counties (Bastrop, Lee, Fayette, Colorado), counseling services. Thrift Store. 24 HOUR HOTLING – 888.311.7755 Violence Offender Program on sliding scale fee. All other programs are free.
Middle Earth Youth Options	1221 West Ben White Blvd. #108-A Austin, TX 78704 512-441-8336 and 735-2400	Services to Runaway Youths, Family Counseling, Shelter
Passages to Recovery	52 South Main Street Loa, UT 84747 866-625-8809	Adults Only
Political Asylum Project of Austin	1715 E. 6th #200 Austin, Texas 78702 512.478.0546	Program representing immigrant survivors of abuse. Appointments available to provide free legal council to immigrant victims of domestic abuse.
Red Cliff Ascent	Enterprise, UT 800-898-1244	Male and Female 13-18
Safe Place	P.O. Box 19454 Austin, Texas 78760 Website: austin-safeplace.org 512.267.SAFE (7233)	Provides crisis intervention, prevention and long term support to survivors of sexual and domestic violence in the Austin/Travis Co. area. 24

		hour hotline, emergency shelter, counseling, transitional housing, school bases services, extensive advocacy and community outreach. Serves women, children and men.
Sandstone Health Care	8820 Business Park, #400 Austin, TX 78759 512-346-9800 fax: 512-346-9840	Free screening and assessments for chemical abuse or dependency

HEALTH

Facility Name	**Address & Phone Number**	**Services/Description**
All Saints Episcopal Church – Loaves and Fishes Program	209 W. 27th St. 78705 512.476.3589	Provides financial assistance with prescriptions, medical bills, eyeglasses and other needs. Assistance is offered on Tuesday mornings only, 6am-9am.
American YouthWorks Clinic	216 E. 4th St. 78701 512.236.6138	Provides outpatient medical clinic for youth, ages 16-25, who have no health coverage (excluding CHIP and Medicaid), or who need confidential reproductive health services.
Austin State Hospital	4110 Guadalupe Street Austin, TX 78751 512-452-0381	State Funded Psychiatric Inpatient & Residential
Austin/Travis Co. Health & Human Services – Health Centers	David Powell Clinic – HIV Services 4614 North IH35 78751 512.972.4278	
	East Austin Health Center 211 Comal St. 78702 512.972.4322	
	East Rural Center (Manor) 600 West Carrie Manor 78653 512.272.8881	
	Montopolis Health Center 1200-B Montopolis Dr. 78741 512.972.6240	
	North Rural Center 15822 Foothill Farms Loop 78660 512.251.6094	
	Northeast Health Center 7112-Z Ed Bluestein Blvd. #155 78723 512.972.4278	
	Oak Hill Community West Rural Center 78656-A Hwy 71 W. 78735	

	512.854.2171	
	Rosewood/Zaragosa Health Center 2802 Webberville Rd. 78702 512.972.4792	
	South Austin Health Center 2529 S 1st St. 78704 512.972.4722	
	South Rural Center (Del Valle) 3518-B FM 973 78617 512.247.4746	
Austin Travis County Medical Assistance Program (MAP)	1111 E. Ceasar Chavez Austin, TX 78702 512.972.5300	Program pays for medical and dental care for eligible Austin and Travis County residents with low income. Some services require a copayment, and all services must be obtained through MAP network providers.
Baptist Community Center	2000 E. 2nd St. Austin, TX 78702 512.478.7243	Provides emergency prescriptions and other basic assistance.
Blackstock Family Health Center	1313 Red River St. Austin, TX 78701 512.324.8600	Provides general outpatient medical services in a primary care setting.
Brackenridge Hospital	601 E. 15th St. Austin, TX 78701 512.324.7000	An acute care hospital and outpatient facility, and Level II Trauma Facility.
Capital Area Mental Health	Hotline 512-472-4357	Sliding scale work with children and adults
Caritas of Austin	611 Neches Austin, TX 78701 512.472.4135	Provides prescription and other basic assistance.
CARE (Community AIDS Resources & Education)	Austin Travis County MHMR Center 1631 East 2nd Street, Building E Austin, TX 78702 512-804-3650	HIV/AIDS Testing, Counseling & Support, Substance Abuse Services
CHC Homeless Clinic	501 E. 8th St. Austin, TX 78701 512.972.4278	Provides primary health care services to people who are homeless.
Children's Wellness Center	3311 S. FM 973 Del Valle, TX 78617 512.386.3330	Provides primary health care services for children, ages 0-21, who live within the Del Valle ISD.
El Buen Samaritano	7000 Woodhue Dr. Austin, TX 78704 512.439.0700	Provides emergency assistance with groceries, clothing, and health services.
Expanded Nutrition Program	611 Carpenter Ave. #201 Austin, TX 78721 512.385.0990	Provide educational information about food and nutrition.
Immunization Branch	1100 W. 49th St.	Provides information by

	Austin, TX 78756 512.458.7284	phone and on their website related to immunizations for children and adults.
Insure-A-Kid/CHIP	1213 N. I-35 Austin, TX 78702 512.324.2447	Determines eligibility for any public health care program for adults and children, including Medicaid, CHIP, county indigent programs, crime victim's compensations and others.
Lifeline	2026 Guadalupe, Room 202 Austin, Texas 78705 512.477.1092 (bad number?)	Help for pregnant women of all ages and circumstances. Pregnancy testing, advocacy, education and referral services. Parenting videos, birthing classes, counseling. Bilingual. Financial and material services for ongoing clients.
Lutheran Social Services	8305 Cross Park Drive Austin, Texas 78754 512.459.1000 lsss.org	Counseling for unplanned pregnancy, adoption counseling, foster care treatment centers. Fees are based on ability to pay.
Marywood Children and Family Services	510 West 26th St. Austin, Texas 78705 marywood.org 800.251.5433 512.472.9251	Maternity care, residential care for teen mothers and pregnant teens, therapy support, educational counseling for unwed mothers, adoption, foster care and placement. Post adoptions services and family counseling.
Medicaid	1165 Airport Blvd 78702 512.929.7330 724 Eberhart 78745 512.445.0022 1601 Rutherford Ln. 78754 512.339.8868	Pays for health services for low-income families. If you think you may be eligible for Medicaid, you should apply as early in your pregnancy as possible. Find out how to obtain a Medicaid application by calling a local office of the Texas Department of Human Services.
North Austin Medical	12221 N. Mopac Austin, TX 78758 512.901.1000	Acute care hospital provides inpatient and outpatient health care services, emergency medicine, maternity services, imaging/x-ray, laboratory, and more.

Peoples Community Clinic	2909 No. IH35 Austin, TX 78722 512-478-4939 OR 478-8924	HIV/AIDS Testing, Prenatal Care, General Medicine. Provides a confidential, full-service health clinic for adolescents, ages 11-19. Focus is on treating the whole person.
Quality Vision Eyewear	2800 S. I-35 #125 Austin, TX 78704 512.462.0001	Provides low-cost eye exams and eye glasses for people receiving Medicaid and post-surgery Medicare.
Royal Eyes-Discount Eyewear Program	9515 N. Lamar Blvd. #136 Austin, TX 78753 512.458.3937	Provides discounted eyewear for people with low income.
Salvation Army	501 E. 8th St. Austin, TX 78701 512.476.1111	Can provide groceries, meals, shelter, and some health services.
Samaritan Health Ministries	700 W. Whitestone Blvd. Austin, TX 78613 512.656.5789	Provides free, non-emergency medical attention to the working poor in north Travis County and parts of Williamson County.
Seton McCarthy	2811 E. 2nd St. Austin, TX 78702 512.324.4930	Provides primary health services.
Seton Medical Center	1201 W. 38th St. Austin, TX 78705 512.324.1000	Acute care hospital.
Seton South Community Health Center	3706 S. 1st St. Austin, TX 78704 512.324.4940	Provides primary health services.
Seton Southwest Hospital	7900 FM 1826 Austin, TX 78737 512.324.9000	
Seton Topfer Clinic	8913 Collinfield Austin, TX 78758 512.324.6850	Provides primary health services.
Shots for Tots	1000 Toyath St. Austin, TX 78703 512.972.5520	Provides free immunizations Hepatitis A and B vaccinations, and tuberculosis screening.
Sight for Students	512.462.1771	Program through Communities in Schools provides free vision screenings and eyeglasses for children with low income living in the AISD area.
Shoal Creek Hospital	3501 Mills Avenue Austin, TX 78731 512-324-2000	Inpatient Crisis Stabilization, Adolescent, Adult Psychiatric/Substance

		Abuse Inpatient /Outpatient
Skippy Express	601 E. 15th St. Austin, TX 78701 512.324.7391	Provides a mobile clinic that offers primary and preventative care to AISD students and their siblings, ages 0-18.
South Austin Hospital	901 W. Ben White Blvd. Austin, TX 78704 512.447.2211	Inpatient and outpatient health care services.
St. Austin's Catholic Church-St. Vincent de Paul Society	2026 Guadalupe Austin, TX 787053 512.477.1589	Provides emergency financial assistance. May assist with glasses and prescriptions.
St. David's Hospital	919 E. 32nd St. Austin, TX 78705 512.476.7111	Provides inpatient, outpatient, and emergency medical.
St. David's Pavilion	1025 East 32nd street Austin, TX 78705 512-867-5925	55 years and older, Psychiatric ONLY
St. John's Neighborhood Center	7500 Blessing Ave. Austin, TX 78752 512.972.5159	Provides health-related services.
STAR Health Plan	866.566.8989	Offered in Travis County for families on Medicaid and Temporary Assistance for Needy Families (TANF). If you are eligible for this plan, it will allow you to choose your own doctor from a list of doctors and health centers near you. Can pay for counseling as well as other health services.
Trinity Center as St. David's Episcopal Church	304 E. 7th St. Austin, TX 78701 512.472.1196 (ext. 142)	Provides people who are homeless with funds for IDs/birth certificates, prescriptions, and some dental work
WIC Immunization Program	800.942.3678 800.WIC.FOR.U	Provides free immunizations to children participating in the WIC program.
Volunteer Health Care Clinic	4215 Medical Pkwy. Austin, TX 78756 512.459.6002	Provides non-emergency medical treatment for children and adults who have low income, and have no other access to health care. Provides primary care services for acute and chronic conditions.

DENTAL

Facility Name	Address & Phone Number	Services/Description
Dental Services for Travis County Residents Outside Austin City Limits	Del Valle Clinic 2518 FM 973 78617 512.247.4407	Dental clinics providing care to those that live outside of Austin.
Manos De Cristo Dental Clinic	1201 E. Cesar Chavez Austin, TX 78702 512.477.2319	Provides dental services for low income families that do not have MAP or Medicaid, call first to determine services.
NE Austin Dental Clinic	7112 Ed. Bluestein Austin, TX 78723 512.972.4830	Provides variety of dental work for Medicaid and MAP families living with in the city limits. Appointment only.
RBJ Clinic	15 Waller St. Austin, TX 78702 512.972.4820	Provides variety of dental work for Medicaid and MAP families living with in the city limits. Appointment only.
South Austin Dental Clinic	2529 South 1st St. Austin, TX 78704 512.927.4840	Provides a variety of dental work for Medicaid and MAP families living within the Austin city limits. Appointment only.

FAMILY PLANNING HEALTH SERVICES

Facility Name	Address & Phone Number	Services/Description
American Youth Works Clinic	216 E. 4th St. Austin, TX 78701 512.236.6138 512.236.6916 (appts.)	
Austin Health Connection	15 Waller St. RBJ #324 Austin, TX 78702 512.972.5419	
Austin Travis County Community Health Centers	Call for nearest: 512.972.4278	
Austin Women's Health Center	512.443.2888	Confidential location
Blackstock Family Health Center	1313 Red River #100 Austin, TX 78701 512.324.8600	
Family Planning Program	Del Valle Clinic 3518 FM 973 S Del Valle, TX 78617	Physical exams, pregnancy testing, birth control supplies, family planning information, education and counseling, referrals and follow up for medical

		problems, treatment for minor gynecological problems, HIV testing
People's Community Clinic – Family Planning and Prenatal Clinic	2909 N. IH35 Austin, TX 78722 512.478.8924	
Planned Parenthood	1823 E. 7th St. 78702 512.477.5846 201 E Ben White Blvd Austin, TX 78704 (512) 276-8000	Downtown office: teen program from 2-6:30 pm. Walk-ins ok for pregnancy testing.
Reproductive Services of Austin	4804 Grover Ave. Austin, TX 78756 512.458.8274	
Whole Women's Health	8401 N. IH35 #200 Austin, TX 78753 512.250.1005	

PREGNANCY OPTIONS

Facility Name	**Address & Phone Number**	**Services/Description**
Adoption Affiliates	4804 Grover Ave. Austin, TX 78753 512.454.1655 800.441.8695	Provides adoption placement for women experiencing an unplanned pregnancy.
Any Baby Can	1121 E. 7th St. Austin, TX 78702 512.454.3743	Provides labor and delivery classes.
Austin Travis County Medical Assistance Program (MAP)	1111 E. Cesar Chavez Austin, TX 78702 512.972.5300	Pays for the cost of an abortion at less than 13 weeks with a $25 co-pay.
Austin Women's Health Services	512.443.2888	Provides abortion services, pregnancy options counseling, and referrals
Baby Moses Project	361.578.6694	"Safe Havens" – any hospital, fire rescue, emergency med tech.
Family Planning Program	7501 Blessing Ave. Austin, TX 78751 512.451.0252	Offers support and information to pregnant and parenting teens.
Gabriel Project	203 E. 10th St. Austin, TX 78701 512.238.1246	Provides emotional support to women experiencing an unplanned pregnancy.
Jane's Due Process	P.O. Box 3478 78764 Janesdp.org 866.999.5263	Provides a toll free hotline to pregnant minors to learn more about parental notification regarding abortions and judicial bypass of the law. Offers referral for free

		representation by a lawyer in judicial bypass process. Also provides referrals to pregnant minors seeking a protective order against abusive parents and information regarding emancipation to become legal adult.
LifeWorks Teen Parent Services	512.735.2100	Provides case mtg. to pregnant and parenting teens wishing to stay in school.
The Lilith Fund	PO Box 684949 Austin, TX 78768 877.659.4304	Provides direct financial assistance for women seeking abortion services.
Lutheran Social Services Unplanned Pregnancy Program	8305 Cross Park Dr. Austin, TX 78754 800.938.5777	Offers support and assistance to women experiencing an unplanned pregnancy and considering adoption.
Marywood Children and Family Services	510 W. 26th St. Austin, TX 78705 512.472.9251	Offers residential care and support to young women experiencing an unplanned pregnancy.
National Hispanic Prenatal Helpline	800.504.7081	Provides toll free helpline that answers questions regarding pregnancy in both English and Spanish. Offers referrals to local prenatal health care service providers and sends written information about pregnancy issues.
Reproductive Services	4804 Grover Ave. Austin, TX 78756 512.458.8274 800.887.7285	Provides surgical and medical abortions (also known as RU-486 abortion), pregnancy options, counseling, and referrals
Whole Women's Health	8401 N IH35#200 Austin, TX 78753 512.250.1005	Provides abortion services, pregnancy options, counseling, and referrals.

CHILD CARE

Facility Name	**Address & Phone Number**	**Services/Description**
Child Incorporated	818 E. 53rd St. Austin, TX 78751 512.451.7361	Provides Head Start and Early Head Start childhood development programs for children ages 0-5. Call for eligibility and wait list info.
Community Advocates for	7501 Blessing Ave.	Provides childcare on a

Teens & Parents (CATP) – Knights & Lassies Child Care Center	Austin, TX 78752 512.451.0252	sliding scale fee.
Day Care Information Hotline	DFPS – 800.862.5252	Provides listings for family day homes and licensed day cares.
Ebenezer Child Development Center	1014 E. 10th St. Austin, TX 78702 512.478.6709	Offers childcare on a sliding scale fee.
Family Connections	1301 Capital of TX Hwy. C-210 Austin, TX 78746 512.327.7660	Provides customized searches for child care providers. Maintains a list of daycares that operate on a sliding scale.
Generations Children, Inc.	1610 Wheless Ln. Austin, TX 78723 512.206.0766	Offers childcare to teen parents who are currently in school.
MainSpring School	1100 West Live Oak Austin, TX 78701 512.442.2301	Provides full day program of early education and care for young children on sliding scale.
WorkSource Child Care Solutions	6505 Airport Blvd. #101-C Austin, TX 78751 512.302.0710	Offers childcare financial assistance. Parents must be working on in schools. Priority given to teen parents.

PARENTING SUPPORT AND CLASSES

Facility Name	**Address & Phone Number**	**Services/Description**
Any Baby Can Family Resource Center	1121 E. 7th St. Austin, TX 78702 512.454.3743	Provides early childhood intervention services, and parenting education. Support groups are offered in English and Spanish.
Austin Child Guidance Center	810 West 45th St. Austin, TX 78751 512.451.2242	Provides evaluation and treatment of emotional and behavioral problems. Also offers individual, family, and group therapy as well as school based group services.
Austin Travis County WIC Program	City of Austin Health and Human Services Dept. 512.972.5400	Offers breastfeeding and nutrition information. Call for nearest location.
ASPIRE Even Start	1711 Wheless Austin, TX 78723 512.414.5667	Provides parenting education to parents of young children. Also offers early childhood education for children ages 2 months to 5 years while parents attend ESL or GED classes.
AVANCE-Austin	3000 S. IH35 #205 78704	A parenting program that

	CORE – 512.326.9335 EVEN START – 512.389.3394	offers classes and support in parenting skills. Call for closest locations.
Bureau of Vital Statistics – TX Department of Health	1100 W. 49th St. Austin, TX 78756 512.458.7111	Provides birth, death, marriage, and divorce records for a fee.
Community Advocates for Teens & Parents (CATP)	7501 Blessing Ave. Austin, TX 78752 512.451.0252	Offers a variety of support for teen parents and their children including shelter, parenting classes, childcare, clothing, job readiness.
Communities in Schools	3000 S. IH35 #200 Austin, TX 78704 512.462.1771	Offers dropout prevention programs, counseling, tutoring, life skills training, and support for teen parents.
Family Connections	825 E. 53 ½ #E-101 Austin, TX 78751 512.478.5725	Provides training opportunities to parents and childcare providers. A free information line is also available as well as a lending library of children's books, toys, videos, and research articles for parenting, child development, and early childhood education.
Family Forward	7801 N. Lamar #E180 Austin, TX 78752 512.459.5490	Provides free telephone support for parents and caregivers. Support and educational programs provided through a statewide network of partner agencies for parents and children.
Gabriel Project	203 E. 10th St. Austin, TX 78701 512.238.1246	Matches volunteers with women in any stage of pregnancy as mentors. May also assist with baby and toddler items depending on availability.
La Leche League	512.272.8042 512.443.6370 (Spanish speaking)	Offers support and information on breast-feeding and parenting. Call for nearest location.
Latina Mami	5812 Berkman Austin, TX 78723 512.494.7758	Provides a support network to parents through parenting classes, play groups, and a clothing closet.
LifeWorks – Teen Parent Services	512.735.2100	Offers case management to pregnant and parenting teens. Information regarding nutrition, health, birth

		control, education, parenting, etc. Call for nearest location.
Marywood Children and Family Services	510 West 26th St. Austin, Texas 78705 marywood.org 800.251.5433 512.472.9251	Maternity care, residential care for teen mothers and pregnant teens, therapy support, educational counseling for unwed mothers, adoption, foster care and placement. Post adoptions services and family counseling.
Mom's Place	9411 Parkfield #310 Austin, TX 78705 512.472.9151	A WIC Breastfeeding Resource Center that offers information and support.
People's Community Clinic Tandem Teen Prenatal & Parenting Program	2909 N. IH 35 Austin, TX 78722 512.708.3130	Family focused services for pregnant and parenting teens.
Safe Place Baby Safe	512.267.7233	Provides crisis intervention, safety planning, counseling, and parenting education to women in a domestic violence situation.
Safe Riders Traffic Safety Program	1100 W. 49th St. Austin, TX 78756 800.252.8255	Offers car seat installation and workshops for teen parents on car seat safety. Can provide car seats depending on availability.
Social Security Administration	903 San Jacinto 78701 512.916.5404 800.772.1213	Assists with applications for Social Security cards.
St. David's Medical Center	919 E. 32nd St. Austin, TX 78705 512.397.4226	Offers family education classes, childbirth, parenting, and health related classes.

PREVENTING ABUSE AND NEGLECT

Facility Name	**Address & Phone Number**	**Services/Description**
Austin Child Guidance Center	810 W. 45th St. Austin, TX 78751 512.451.2242	Offers counseling for physically and sexually abused children.
Austin Police Department	715 E. 8th St. 78701 Child Abuse Unit – 512.834.3890 Victim Services – 512.947.5037	Offers crisis intervention and advocacy.
Baby Moses Project	361.578.6694	State law allows new mothers an alternative to newborn abandonment. Mothers may choose to leave their newborn, less than 60 days old, without being prosecuted at any

		hospital, fire rescue station, or emergency medical technician in TX.
CASA of Travis County	6330 Hwy 290 #350 Austin, TX 78723 512.459.2272	Provides court appointed advocates for cases, child abuse and neglect.
Center for Child Protection	1110 E. 32nd St. Austin, TX 78722 512.472.1164	Offers crisis counseling for young victims.
Department of Family & Protective Services/Abuse & Family Violence Hotline	800.252.5400 (24 hours)	Receives and investigates all abuse and neglect complaints.
Family Forward	7801 N. Lamar #E180 Austin, TX 78752 512.459.5490	Provides support to parents or providers who are feeling stress and feel they may become abusive.
LifeWorks Family Diversion Network	2001 Chicon St. Austin, TX 78722 512.735.2100	Offers support and services to those wishing to get help with their anger.
MHMR of Austin/Travis County	512.472.4357 866.693.6727 (Single point of entry)	Offers service referrals and crisis intervention
Safe Place	512.267.SAFE	Provides crisis intervention, prevention, and long-term support to survivors of sexual and domestic violence.

SERVICES FOR CHILDREN WITH SPECIAL NEEDS

Facility Name	**Address & Phone Number**	**Services/Description**
Advocacy Inc.	7800 Shoal Creek Blvd #171E Austin, TX 78757 512.454.4816 800.252.9108	Provides information to parents of children with special needs regarding their rights.
Any Baby Can	1121 E. 7th Austin, TX 78702 512.454.3743	Provides support services to families of children with chronic illness of disabilities. Offers screen, assessment, and home visits for infants and toddlers who may have a delay in their mental, physical, or emotional development. Early childhood intervention services and parenting education and support groups are provided in both eng and span.
Arc of Capital Area	2818 San Gabriel Austin, TX 78705 512.476.7044	Provides services to children with developmental disability. Offers case management, workshops,

		and information and referral.
Case Management for Children & Pregnant Women –TDH	1100 W. 49th St. Austin, TX 78756 512.458.7111	Provides case management to families with children who have a high-risk condition or to pregnant women who have a high risk condition
Early Childhood Intervention	800.250.2246	A no cost program from children ages 3 and younger that provide speech or physical therapy. Call for locations.
Easter Seals	919 W. 28 ½ St. Austin, TX 78705 512.478.2581	Provides support and information, including early intervention programs and early education and care programs.
Family Health Services – THD	1100 W. 49th St. Austin, TX 78756 800.422.2956	Offers a statewide information and referral line for health care services
Infant Parent Program	1717 W. 10th St. Austin, TX 78703 512.472.3148	Provides support to families with children who have developmental delay from birth to 3 years.
Open Door School	1717 West 10th St 78703 512.477.9632 603 Bouldin 78704 512.445.2698 3804 Cherry Wood 78722 512.481.0775	Provides childcare and inclusive programs for children with and without special needs.
TDH Social Work Services & Children with Special Health Care Needs	1101 Camino La Costa #210 Austin, TX 78752 512.467.9875	Provides case management for low-income families who have a child with a chronic health condition in addition to pregnant women with a health condition.

Appendix E: Summary of Interviews with the *Curandero* and Priest

The Curandero

Mr. Curandero, or *Mr. C.,* was interviewed in his office, which is located within his Mexican imports shop, which is located in the region in which the school district is found. *Mr. C.* was welcoming, and expressed a willingness to talk, but also made it very clear he would only share what he wanted to share, at times brushing off questions asked by the interviewer, maintaining an air of mystery about him.

His age was estimated to be roughly in the late 60s or early 70s. He described his background as being part Aztec and part Spanish, with roots in south Texas. He served in the military, is a war veteran, and was once a prisoner of war. Following his military services, *Mr. C.* worked as a welder, and at times taught at a community college. In 1976, *Mr. C.* began to pursue his path as a *curandero*.

Mr. C. reported he was aware of his abilities as a healer since he was a young child. In fact, he reported that his mother first knew he would be a healer because he, "Cried in [his] mother's womb," which indicated he was born with "A gift from God." At a young age, his mother used to have him heal people by touching them, or by using his saliva on wounds. Although he knew of his abilities and was aware of a "sensitivity" that others did not possess, *Mr. C.* did not pursue his "calling" as a healer until, in 1976, he had an "encounter" in which, "A voice started talking to me. It told me what I was supposed to do with my life… that I had a connection to a higher up. This is why [I] had the capability all along." This capability was the ability to heal.

At this point, although *Mr. C.* had grown up Catholic, he began to study with a pastor through Saint Paul's Church of Religious Science because, "The Catholic church did not have all the answers." He also reported that, "The Catholic church is touchy about healing. Only priests are able to do healing," and indicated he did not agree with that assertion. *Mr. C.* then described that in his work as a healer, he was careful only to work in the "light" and not in the "dark." He explained there are good spirits and evil spirits, and that in order to truly work on behalf on God to do good, a *curandero* could not work with the dark, or the evil side of things. He believes there is a "misunderstanding" that all *curanderos* work in the dark.

I then asked *Mr. C.* what types of services he offers as a *curandero.* He reported he offered a "potpourri" of services that include: "cultural cleansing" (*limpias* and *barridas)*, reading of cards, *sobadas* (healing massages), "psychic surgeries", as well as counseling. He also offered over 200 different types of herbs, as well as an assortment of candles and amulets in his store. These could be recommended after a treatment for his clients to use at home.

I asked *Mr. C.* what types of problems he helped his clients with, and whether he worked much with adolescents. *Mr. C.* described that the most common procedure he practices on his clients is the exorcism of entities. *Mr. C.* described that sometimes, "When kids behave badly is when they have a bad spirit inside of them." This spirit then puts a "damper" on the person, such that they do not behave the way the normally would. He said this could look like a "bad attitude," which is often what parents come in complaining about, or that a person is acting "mischievously." *Mr. C.* stated that someone

could come to "accumulate" multiple entities. One way someone can come to possess a bad spirit inside of them is if someone else passes the entity on to them, which occurs through close contact, including kissing or breathing near some. Another way is if someone puts a hex on that person.

The way in which *Mr. C.* treats the person will vary based on the individual case. Generally, *Mr. C.* begins by doing a reading of cards to try to determine what is causing the problem. *Mr. C.* also uses an egg, which he described as a "tattletale," to help determine what the motivation behind a hex is. By sweeping an egg over a person while praying some specific prayers, and then breaking the egg and analyzing it, he can determine what the "tiedown" is, and it can indicate whether the person has been hexed out of greed, jealousy, or some other reason. Once *Mr. C.* has an idea of what is going on with the client, he begins his procedure of cleansing them. Although he did not provide much detail, he described it involved a lot of prayer while "sweeping" the person with a variety of herbs. He reported that sometimes it takes multiple attempts before the entities are completely exorcised. When they finally are exorcised, the person vomits out mucus.

Mr. C. reported that in doing some of his cleansings, he at times "channels" other spirits to perform the healings. He reported he has been able to channel the spirits of Don Pedrito Jaramillo and El Niño Fidencio, two well-known *curanderos* who practiced in Mexico and the U.S. in the late 1800's and early 1900's. *Mr. C.* also reported that he could channel all the saints, as well as the Virgin Mary, the *Virgen de Guadalupe*, Jesus Christ, the Holy Spirit, and God.

When asked about what his counseling services involve, *Mr. C.* reported that he helps, "Counsel people to move on from past trauma." He described an example in which he was helping a young woman deal with the early childhood trauma of sexual abuse at the hands of her stepfather. He also described an example in which helped a woman deal with the ramifications of some of the actions she had taken while there was an entity inside of her. *Mr. C.* believed he could help people with a variety of emotional problems.

When asked about his clientele, *Mr. C.* reported that there is a wide range from "PhD's to illiterates." He also reported that he has worked with people of diverse cultural background, including people from Mexico, Puerto Rico, Cuba, Honduras, Japan, China, Korea, and non-Mexican Americans. When asked why he believed people in this study reported not believing in *curanderos* or that they are evil or associated with witchcraft, *Mr. C.* claimed they are "Ignorant people who don't do research." He said that if people really took the time to understand what a true *curandero* does, they would not be afraid. He also stated that it is important to consider a *curandero's* credentials, pointing to some of his own certificates which asserted his status as a *curandero.* One such certificate was from the Church of Religious Science, through which he further developed his healing abilities. He reported that there others out there who pretend to be *curanderos*, but are in fact "charlatans" who use "trickery" to steal from people.

Mr. C. did describe *curanderismo* as a "dying culture." He said the reason this is happening is because people, "Don't seek it anymore." He attributed this to the same fact that people are not informed about what a *curandero* is. Furthermore, he believed that

those who practiced and were not, in fact, true *curanderos* were ruining the reputation of people like himself and others who are true healers.

Today, *Mr. C.* has been practicing in the same place in central Texas for over 23 years, although he considers his journey as a healer to have spanned his entire lifetime. He has served thousands of people over the years, and has a faithful following of regular clients. He said much of his clientele has come to him through "word of mouth," but that there are no longer as many as he saw at one point. His concluding remarks during the interview summed up his belief that he is a healer through the gift God has given him: "I don't do it. I say God does it through me."

The Priest

Father P. is the priest in one of the two Catholic churches that primarily serve the area in which the participating school district is located. He has been a pastor in that same parish for over 27 years. He described his parishioners as predominantly Mexican-American and of low socio-economic status. Father P., however, is Anglo, but is fully bilingual. He conducts services in both English and Spanish.

When asked about the services the church offers to families experiencing difficulties, particularly with adolescents, Father P. reported that the Catholic church has a program that is affiliated with a local hospital in which families can receive medical treatment or counseling on a sliding scale. He reported there are also youth groups in which participants are given an opportunity to interact with other youth in the context of the church's teachings. He also stated that he and the two nuns in the parish are also available during office hours, but that in his experience, not a lot of people had sought his

help over the years. In fact, he reported that over the last year, not a single parent in his parish had made an appointment to speak to him.

Father P. expressed a belief that a lot of members of his community ascribe to the "Myth that we can take care of ourselves." He reported that many of the mothers he knows have a mentality that says, "I take care of my problems, you take care of yours." He expressed that these mothers do not realize "We have to take care of each other's kids."

Father P., however, also made a distinction between the types of services he can offer and what people believe they can get from a priest. He stated that while many people believe a priest may be able to "counsel" a person, he, in fact, believes that a counselor is one who actually has a degree in counseling, not in theology, like he and the nuns do. He believes the help he can offer is more related to "spiritual" guidance based on the church's teachings or the bible.

When asked about *curanderos* in the community, Father P. expressed a sense that they are a presence in the community. With regard to whether people are actually turning to *curanderos*, he responded, "It's almost impossible to tell. It's dangerous to generalize… You'd be surprised at the range of people who go see *curanderos*. There's a range in education." Ultimately, however, Father P. could not say how prevalent he believed their use was in the community. When asked what his sense was of what his parishioners think of *curanderos*, Father P. stated, "*Curanderos* have a reputation. People are afraid. They think they're all atheist. I don't know where that [belief] came from." In fact, Father P. believes there are healers who are "Simply people who pray for other

people. Who use herbal remedies." He believes there is nothing wrong with the use of such healers, provided they are not practicing in anything that could be considered "anti-Christian." Father P. stated that if someone is healing in the name of God, he did not see that as being very different from what he himself does as a priest. However, "When you get away from that you get into magic." When a person invokes evil sprits or non-Christian entities, then the Catholic church does not condone it. Father P. further explained his belief that *curanderos* are practicing something that is based in history, "Something that is based on the science of the day. A native American tradition." He cautioned that you need to "Treat all *curanderos* very gingerly," and that "By their fruits you will know them." Furthermore, Father P. expressed, "Some I am concerned are right out frauds. Charlatans who swindle people out of hundred and thousands of dollars." He believes it is important to know what a "healer's" motivation is. He believes that if it is money, a person may "Discover problems you didn't know you had. It's going to cost you to get out."

In conceptualizing the help-seeking behaviors of his parishioners, Father P. expressed that sometimes people may seek out solutions that are not appropriate to what the problem really is. He said this is one the dangers of seeking help from either a *curandero* or a priest when it is not indicated. He went on to relate a story of a mother who sought the church's help several years ago because she believed her adolescent son was seeing devils. Father P., accompanied by another priest, quickly determined that what the child actually needed was psychiatric help. His colleague, however, believed that by performing a blessing of the house, which is what the mother was seeking, they

would more readily be able to convince her that the problem was not an evil spirit, but actually a mental health problem. Father P. reported that the process was therapeutic for the mother because once she saw that there were no evil spirits behind her son's behavior she was more willing to seek appropriate help for him.

Father P., however, was quick to point out that although that particular case did not have anything to do with the spiritual:

> We underestimate in our society the presence of the spiritual. The supernatural. Of what we can't quite see under the microscope. I don't mean to be anti-science. But the person who lives in the spiritual world is in denial, as is the one who is all science. There is stuff out there that we don't know.

Appendix F: Groups of Categories and Sub-Categories

Children growing up healthy:

- Healthy home environment
    - Basic necessities: food, cleanliness
    - Learn by example: respect
    - Harmony with spouse
    - Expression of love
    - Stability
- Positive interactions between parents and kids
    - Parental involvement/activities with kids
    - Encouragement/support
    - Communication
    - Attention
    - Being their friend
- Parents provide guidance
    - Increase self-esteem in children
    - Transmission of family values
    - Supervision
    - Protecting
    - Advice
- Characteristics
    - Happy
    - Active
    - Free of problems
    - Able to focus on school

Problems adolescents face:

- Family
    - Instability: divorce, neglect
    - Parental problems
    - Lack of support
    - Too much freedom for kids/lack of supervision
- School
    - Academic failure
    - Truancy
    - School violence
    - Lack of support: personnel, personnel caring
    - Drop-out
    - Stress: academic, TAKS
- Peers
    - Pressure
    - Interpersonal difficulties: bullying
    - Fitting in: looks, material possessions, being liked

    - Gangs: violence, drugs
    - Sex: STDs, pregnancy, abortion
    - Prejudice
- Behavioral/Individual factors:
    - Bad choices
    - Anger
    - Self-esteem: looks, weight
    - Rebelling
    - Suicide

<u>Family as a resource in times of need:</u>

- There is a relationship between how close a mother feels to her family (siblings, cousins, parents, compadres, etc.) and their willingness to seek them out in times of need.
- Advice
    - "Been there" (experience)
- Support
    - Listen
    - Are there for you

<u>Church/spiritual in times of need:</u>

- (There is a relationship between the amount of participation in church and willingness to seek help)
- God
    - Listens, provides what we need
    - Relationship with God
- Prayer
    - To calm down
    - Peace
    - Strength
    - Courage
- Religious figures
    - Provide resources
    - Advice

<u>Mainstream, Western resources</u>

- "Professionals"
    - Doctors
        - Can refer to someone
    - Psychologists
        - Helpful in talking to children
        - Children more comfortable talking to someone they don't know
        - They know who to deal with these types of problems
        - *Manzanilla*

        - *Menta*
        - *Anis*

Schools as a resource

- Teachers
    - Provide insight to parents
- Counselors
    - Someone adolescents can talk to
    - Provide guidance
- Nurses
    - Provide guidance
    - Provide resources

Alternatives:

- Curanderos
    - Related to "evil spirits"
    - Not useful
    - Against Catholic faith
    - "Over there, not here" (seen more in Mexico than U.S.)
    - Have had some experience as a child, *or* know someone who would use
    - Work on problems such as:
        - *Mal de ojo* (evil eye)
        - *Limpia* (a cleanse)
    - Few: Might be interesting to see what they say
    - Do not have knowledge of where to look for one in the community
- *Hierbas* (herbs)
    - Helpful for somatic complaints (stomach, indigestion, to calm)
        - *Manzanilla*
        - *Menta*
        - *Anis*

Appendix G: Participant Profiles

Macrina is a 47-year-old mother of 17-year-old male twins, and a 25-year-old son. She has been married for 27 years. She has a college education and is currently bilingual 1st grade teacher. Macrina is unsure as to how long her family has been in the U.S., but assumed she was at least 3rd generation. She considered herself to be fully bilingual. Macrina is Catholic and is actively involved in her church. Macrina considered herself to have a very close relationship to her one sister. Her 17-year-old sons had no history of significant emotional or behavioral problems. Macrina, however, was open to seeking out the help of her family, her church, school staff, doctors, psychologists and other "professionals", but did not believe she would be open to seeking out the help of a *curandero* or *hierbero* if problems came up with her adolescent sons.

Magdalena is a 34-year-old mother of one 16-year-old son. She has been married for 8 years, but has been in a relationship with her husband for 18 years. Magdalena has a high school education, and currently works in a computer-related field. She considers herself to be a 4th generation Mexican American, and although her primary language is English, she reported some limited proficiency in Spanish. Although Magdalena considered herself Catholic, she reported she did not attend services regularly, although she did pray daily. She reported a "really close" relationship with her 4 siblings, her mother, and her step-father. Her 16-year-old son had not history of significant emotional or behavioral problems. Magdalena, however, was open to seeking help from her husband, her family, the school, professionals such as doctors or therapists, and religious

figures from her church, but was not open to seeking the help of a *curandero* or *hierbero* if a problem should arise with her son.

Marina is a 36-year-old mother of two daughters, ages 4 and 16 years. She has been married for 8 years. Marina has a high school education, and currently works as a secretary. Marina considers herself 3rd generation Mexican American, and is proficient in English and Spanish. Marina considers herself a Christian, and attends church regularly. She described having a close relationship with her 4 brothers and sisters, as well as her mother and grandmother. Marina reported her 14-year-old daughter had not experienced any significant emotional or behavioral problems. Marina, however, was open to seeking out help from her family, her daughter's school, her doctor, but would not consider going to the church because it would not be helpful in dealing with adolescent problems. Marina was also not open to the use of *curanderos* or *hierberos* because they, too, would not be helpful.

Marisol is a 38-year-old mother of a 14-year-old girl and a 12-year-old boy. She has been married for 17 years. Marisol is a recent immigrant who has been in the U.S. for 15 years and she speaks Spanish only. She has an elementary level education, and currently works as a child-care provider. She has 6 brothers and sisters, and considers herself close to her 2 sisters. Marisol considers herself Catholic, although she and her family do not attend church regularly. Marisol's 12-year-old son has a history of getting in trouble at school for fighting. When this problem arose, Marisol dealt with it by talking to her son, as well as by talking to her sisters to get advice and support. She reported that if she were to face other more serious problems she would be open to seeking out the

help of the church, school counselors, psychologists and doctors, but would not consider the use of *curanderos.*

Marta is a 37-year-old mother of 5 children, ages 9, 13, 16, 18, and 20 years. She has been married for 21 years. She is an immigrant from Mexico who has been in the U.S. for 21 years and speaks Spanish only. She reported that she did not have "much" of an education, and is currently a housekeeper. Marta reported that none of her adolescent children had experienced significant emotional or behavioral problems. Marta, however, was open to counting on her husband, her family, her church, her children's' school, and her doctor, but would not consider the use of *curanderos.*

Matilde is a 50-year-old mother of one 13-year-old daughter. Matilde is a widow. Matilde is a 2nd generation Mexican American and considers herself to be fully bilingual. She has a bachelor's degree in education, and has recently become certified to be a bilingual teacher, although she currently works as a secretary. She considers herself Catholic, and attends church regularly. She is the oldest of three, and considers herself close to her sister and her brother. Matilde reported her daughter had not experienced any significant behavioral or emotional problems. She reported that if a problem were to arise, her first approach would be to talk to her daughter, and would also consider talking to her siblings who might have had similar experiences. She believed the church would be helpful, and would also be open to contacting her daughter's school, as well as consult with her doctor. Matilde reported that she would not seek out the help of a *curandero.*

Mayra is a 48-year-old mother of three daughters, ages 10, 15, ad 20 years. She has been married for 28 years, although she is in the process of getting divorced. Mayra is

a 2nd generation Mexican American and she considers herself to be fully bilingual. She has a high school education, and is currently working as an aide at a high school. Mayra considers herself Catholic, although she does not attend church regularly. She considers herself to be close to her one sister, as well as her husband's brother. Mayra reported that she had experienced the problem of her 15-year-old daughter not wanting to go to school when she was a 9th grader. In the past she has turned to her sister, and would be open to seeking help in the school, and with professionals, but would not consider going to a priest, as she does not belong to any particular church. She is also not open to seeking a *curandero* because she does not believe they would be helpful.

Mercedes is a 52-year-old mother of 4 sons, ages 17, 28, 20, and 34 years. She has been married for 35 years. She considers herself to be the 5th generation in her family, and considers herself to be primarily English-speaking, although she reported understanding Spanish. She has a high school education, and she and her husband are currently business owners. Although Mercedes grew up Catholic, she considers herself Baptist, and reported attending church and bible study regularly. She considers herself to be close with her 5 siblings. Mercedes reported that she had experienced problems with her 17-year-old being "lazy" with his school work. To address the problem, Mercedes has tried talking to him, talking to her husband, praying, talking to his teachers and counselors, and getting him tutoring through a private tutoring program. Mercedes, however, would be open to seeking out the help of clergy from her church if other problems would arise, and was also open to seeking the services of a *curandero*, as she

had previously had positive experiences with a *curandera* who had helped one of her sons when he was young and was given *el ojo*, or evil eye.

Monica is a 39-year-old mother of 4 children, ages 10, 14, 15, and 18 years. She has been married for 19 years. She is a 2nd generation Mexican American, and considers herself to be fully bilingual. Monica has a high school education, and currently works as a youth minister and as a substitute teacher. Monica reported that she grew up Catholic, but that now she considers herself a nondenominational Christian who is very involved in her church and in the youth group that she leads. She is the youngest of 4, and is currently close to two of her sisters. She also considers herself "really close" to her mother-in-law. Monica reported that none of her adolescent children had experienced significant behavioral or emotional problems. She believed that if one of her adolescent children were to develop a problem, she would begin by talking to them and giving advice, would talk to her mother-in-law to get advice, would read the bible and pray, and would turn to someone in her church. Monica, however, expressed she would not be interested in seeking help from the school because they "don't know [her] family." She would also not seek out a therapist of psychologist in the community because she felt she could handle the problem within the family. With regard to the use of *curanderos*, Monica reported that she would not seek them out because she believed it was "witchcraft" and "would rather read the bible."

Laura is a 46-year-old mother of 7 children ages 17 to 26 years. She is a single mother who has been divorced twice. Laura is an illegal immigrant who has been in the country for 15 years. She primarily speaks Spanish, although she reported she speaks

some English and understands it well. She reported she had never attended school as a child. She is currently employed as a custodian for a construction company. Laura considers herself a Catholic, but does not attend church regularly. Laura considers herself to have a strained relationship with most people in her family, including her mother and siblings. Laura reported that she has experienced a number of problems with her adolescent son, including academic problems at school, truancy, depression, and drug use. Her son is currently receiving counseling services through the special education department. Laura's approach in dealing with her son's problems has been to talk to him, as well as seek out the help of school personnel. Although she has had negative experiences with staff at her son's schools, she is willing to continue to seek help from them because she is not willing to "give up." Laura was open to seeking out the help of other professionals as well. Furthermore, Laura has faith in God, and believes she can count on the church as a place to go "talk" to God. Laura was also open to seeking out the help of people to pray on her behalf for her son's problems, which was her idea of a *curandero*, someone who could help by praying. Laura, however, would not turn to her family for help.

Leticia is a 43-year-old mother of 3 children, ages 16, 17, and 21 years. She has been married for 21 years. Sandra is unsure as to the length of time her family has been in the U.S. Leticia's primary language is English, and she reported speaking very little Spanish. Leticia has a high school education, and currently works as a legal secretary. Leticia considers herself Catholic, but reported she does not attend church regularly. She has two sisters and one brother, and does not consider herself close to her family.

Leticia's 16-year-old son has experienced a number of academic, behavioral and emotional problems at school, and is currently on a behavioral intervention plan and is receiving counseling services through the special education department, and she has been in contact with school staff about his problems. She is open to working with the school and seeking out advice from her doctor, and was also open to seeking out someone in her church. Leticia, however, was not interested in seeking out the help of a *curandero* because it "scares" her.

Lidia is 47-year-old mother of 2 children, ages 16 and 17 years. She has been married for 22 years. Lidia considers herself 3rd generation Mexican American, and speaks primarily in English, with some limited Spanish. Lidia has an associate's degree in nursing, and currently works as a substitute teacher in a nearby school district. She considers herself Christian, and is very involved in her church. Lidia considers herself close to her family, although her siblings are out of state. Lidia's older son has a history of depression, and has been receiving counseling services through the special education department. Lidia's approach to her son's problems has been to pray, and she has been in contact with school personnel. Lidia has also counted on some of her church companions for prayer. Although she has not sought out the help of a doctor or psychologist, she reported she would be open to seeking them out in the future if the need should arise. Lidia, however, was not open to the use of a *curandero* because she believed they are associated with evil spirits.

Linda is a 31-year-old mother of 3 children, ages 10, 11, and 14 years. She is divorced, but currently has a live-in boyfriend. Linda considers herself to be a 5th

generation Mexican American, and her primary language is English, although she reported speaking some Spanish. She has an associate's degree in medical administrator, and currently works as a medical assistant. Linda is Catholic and she reported she attends church regularly, and is very involved in her church. Linda considered herself to be close to her family, and also reported that she had friends who were close "like family." Linda's 14-year-old son has experienced a number of emotional and behavioral problems, as well as some drug use, and as a result he has been receiving counseling services through the special education department at his school. Although Linda does not consider his problems too serious, if something more concerning were to come up, she would be willing to contact the school, talk to someone in her church, as well as seek professional help. Linda, however, would not be willing to seek out the help of a *curandero.*

Lucia is a 43-year-old mother of girls, ages 13 and 14 years. Lucia is in the process of getting divorced. Lucia is 3rd generation Mexican American and considers herself to be fluent in both English and Spanish, although she has a preference for English. Lucia has a high school education, and is currently employed as a secretary in one of the district's schools. Lucia is Catholic and reported that she used to be "very involved" with her church, but has not been lately. She considers herself to be "really close" with her 7 siblings. Lucia's 14-year-old daughter has had a number of emotional problems, which at one point resulted in hospitalization in a local inpatient mental health facility. She has also been receiving counseling through the school's special education department. In dealing with her daughter's problems, Lucia has enlisted the help of her family, her school, mental health professionals, as well as a prayer group she attended

regularly for a while. Lucia, however, does not believe a *curandero* would be helpful with her daughter's problems.

Luisa is a 34-year-old mother of three daughters ages 10, 14, and 17 years. She has been married for 19 years. Luisa is a 2nd generation Mexican American, and is fully bilingual. Luisa has an associate's degree as a registered medical assistant, and currently works at a doctor's office. Luisa is Catholic, but does not attend regularly. Luisa considers herself close to her parents and siblings, as well as to her best friend. Luisa's oldest daughter has a history of mental health problems, and in the past has made suicide attempts, which led to her being hospitalized. Her daughter has also been receiving counseling services at her school. Luisa has turned to her family and best friend in times of need, and although she has also been involved with mental health professionals as well as the school, she expressed the negative experiences she had with them would keep her from seeking their help again in the future. She also expressed she would not find folk healers, such as *curanderos*, helpful and as such would not seek them for problems with her adolescent daughter.

Lupita is a 43-year-old mother of a 21-year-old son and a 17-year-old daughter. She has been married for 22 years. Lupita is a 1st generation Mexican American, and although she is fully bilingual, she expressed a preference for Spanish. Lupita has an associate's degree in early child development, and is working as a care provider in an early childhood center. Lupita is Catholic and considers herself to be very involved in her church. Lupita considers herself very close to her parents and siblings. Lupita's both children have a history of emotional and behavioral problems, and her daughter is

receiving counseling through the special education department. In dealing with some of the problems her children have faced, Lupita has turned to her family for advice, and has sought help through her church and obtained counseling for her children. She is open to seeking help through the school as well as from "professional," but would not seek the help of a *curandero* because she did not "believe in those things."

Sandra is a 36-year-old mother of 4 children, ages 8, 10, 13, and 14 years. She has been married for 14 years. Sandra is a 1st generation immigrant who arrived in the U.S. from Mexico 16 years ago and only speaks Spanish. She has a middle school education from Mexico and is currently employed as a companion to the elderly. Sandra considers herself Catholic, and is very involved in her church. Sandra has 6 siblings and considers herself to have a close relationship to her family. Both of Sandra's adolescent children have had behavioral problems at school and both have been placed at the alternative center. In dealing with problems that have come up with her adolescents, Sandra has talked to her children and given them advice. She has also talked to family members, and has been in contact with the school's counselors. Although she has not previously sought the help of someone like her doctor or a psychologist, she would be open to seeking them out. Sandra, however, would not be open to seeking out a priest or a nun because she believes that it is "not their job," and she would not seek out the help of a *curandero*, but would consider the use of natural herbs for things like stomach aches.

Silvia is a 46-year-old mother of 2 adolescents, ages 15 and 16 years. She has been married for 28 years. Silvia is a 3rd generation Mexican American who considers herself bilingual, although English is her dominant language. Silvia obtained an

education through the 11th grade in high school and currently works as a cashier in a business office cafeteria. Silvia considers herself a Christian, and belongs to a church, but does not attend regularly. She has two brothers and her father, with whom she is close. Her son has a history of behavioral problems at school that have resulted in his placement at the alternative center. In helping her son deal with his behavioral problems, Silvia has tried giving him advice, and usually counts on her husband for support. Silvia would be open to seeking counseling services through her doctor, and would also consider having her son speak to a priest. Silvia, however, would not be open to seeking out a *curandero* because she believes God is the only healer.

Sofia is a 37-year-old mother of 3 children, ages 2, 12, and 15 years. Sofia has been married for 14 years. She reported she is an illegal immigrant who came to the U.S. from Mexico 19 years ago. Her primary language is Spanish, although she understands some English. She has a 6th grade education from Mexico, and currently works as a housekeeper. Sofia is Catholic, although she does not attend church regularly. Her daughter has had a number of behavioral and emotional problems, and in the past has been placed at the alternative center due to fighting. In the past, Sofia has tried talking with her daughter, and has turned to her sister and a cousin for support and advice in dealing with her daughter's problems at school. Sofia has also been involved with her daughter's school in trying to get her some support in the way of counseling. Although she has not done so, Sofia would be open to seeking out help from her church, as well as professionals. Sofia, however, would not be willing to seek out the help of a *curandero*.

Soledad is a 30-year-old mother of 3 children, ages 3, 8, and 12 years. She is divorced and is currently a single mother. Soledad is a 4th generation Mexican American who primarily speaks English, but speaks some Spanish. Soledad has some college education, but never graduated. She currently works as an accountant for an insurance company. Soledad does not consider herself a believer, and does not belong to a religion. Soledad considers herself very close to her parents, but not to her brother, who is much younger than her. Soledad's 12-year-old daughter has experienced some problems at school that led to her being placed in the alternative center for an extended period of time. In dealing with that problem, Soledad responded by talking to her daughter, seeking out help from her ex-husband, seeking out help from the school, and attending parenting classes through the school. Although she did not believe her daughter's problem warranted the help of a doctor, in the future she would be willing to seek that help if necessary. Soledad would not be willing to seek out help through a church, as she does not belong to one. She would, be willing to seek the help of a *curandero* because she would find it "interesting to see what they have to say."

Sonia is a 40 year-old mother of 3children, ages 1, 5, and 12 years. She has been married for 13 years. Sonia is a Mexican immigrant who has been in the country for almost 20 years, and she speaks only Spanish. She has a high school education from Mexico, but is currently a homemaker. Sonia is a Jehovah's Witness who is very involved in her church and attends regularly. She considers herself to not have a very close relationship with her family. Sonia's 12-year-old daughter has had a number of behavioral problems at school, and as a result has had to be placed in the alternative

center. Sonia has dealt with her daughter's problems my talking to her, talking to her church friends, and praying. Sonia believes she would be open to seeking help from the school, as well as her doctor or a psychologist. Sonia, however, would not seek the help of her family because she is not close to them, and she would also not seek out the help of a *curandero* because she does not believe in them.

References

Achenbach, T.M., & Edelbrock, C.S. (1983). *Manual of child behavior checklist and revised child behavior profile.* Burlington, VA: University of Vermont, Department of Psychiatry.

Al-Issa, I., & Oudji, S. (1998). Culture and anxiety disorders. In S.S. Kazarian & D.R. Evans (Eds.), *Culture and clinical psychology* (pp. 127-151). New York: Oxford University Press.

Alvidrez, J. (1999). Ethnic variations in mental health attitudes and service use among low-income African American, Latina, and European American young women. *Community Mental Health Journal, 35*(6), 515-530.

American Academy of Child and Adolescent Psychiatry. (2004). *The continuum of care for children and adolescents, No. 42.* Washington DC: Author.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (text revision). Washington, DC: American Psychiatric Association.

Aponte, J.F., Crouch, R.T. (1995). The changing profile of the United States. In J.F. Aponte, R. Young Rivers, & J. Whol (Eds.), *Psychological interventions and cultural diversity* (pp. 1-18). Boston, MA: Allyn and Bacon.

Barreto, R.M., & Segal, S.P. (2005). Use of mental health services by Asian Americans. *Psychiatric Services, 56,* 746-748.

Baumeister, L.M., Flores, E., & Marin Van Oss, B. (1995). Sex information given to Latina adolescents by parents. *Health Education Research, 10*(2), 233-239.

Belitz, J., & Valdez, D.M. (1997). A sociocultural context for understanding gang involvement among Mexican-American male youth. In J.G. García (Ed.), *Psychological interventions and research with Latino populations* (pp. 56-72). Boston, MA: Allyn and Bacon.

Berry, E.H., Shillington, A. M., Peak, T., & Hohman, M.M (2000). Multi-ethnic comparison of risk and protective factors for adolescent pregnancy. *Child and Adolescent Social Work Journal, 17*(2), 79-96.

Boehnlein, J.K., & Kinzie, J.D. (1995). Refugee trauma. *Transcultural Psychiatric Research Review, 32,* 223-252.

Bogdan, R.C., & Biklen, S.L. (Eds.). (2003). *Qualitiative research for education. An introduction to theories and methods.* Boston, MA: Allyn and Bacon.

Briones, D.F., Heller, P.L., Chalfant, H.P., Roberts, A.E., Aguirre-Hauchbaum, S.F., & Farr, W.F. (1990). Socioeconomic status, ethnicity, psychological distress, and readiness to utilize a mental health facility. *American Journal of Psychiatry, 147,* 1333-1340.

Bronfenbrenner, U. (1990). Discovering what families do. In D. Blankenhorn, S. Bayme, & J.B. Elshtain (Eds.), *Rebuilding the Nest: A New Commitment to the American Family* (pp.27-38). Milwaukee, WI: Family Service America

Brown, E.R., Ojeda, V.D, Wyn, R., & Levan, R. (2000). *Racial and ethnic disparities in access to health insurance and health care.* Los Angeles, CA: UCLA Center for Health Policy Research and Kaiser Family Foundation.

Bui, K., & Takeuchi, D.T. (1992). Ethnic minority adolescents and the use of community mental health care services. *American Journal of Community Psychology, 20*, 403-417.

Burns, B.J., Costello, E.J., Angold, A., Tweed, D., Stangl, D., Farmer, E.M., & Erkanli, A. (1995). Children's mental health service use across service sectors. *Health Affairs, 14*, 147-159.

Burt, M.R., Resnick, G., & Novick, E.R. (1998). *Building supportive communities for at-risk adolescents: It takes more than services.* Washington, DC: American Psychological Association.

Casas, L.M., Wagenheim, B.R., Banchero, R., & Mendoza-Romero, J. (1994). Hispanic masculinity: Myth or psychological schema meriting clinical consideration. *Hispanic Journal of Behavioral Sciences, 16*, 315-331.

Casas, M. (1984). Policy, training, and research in counseling psychology: the racial/ethnic minority perspective. In S. Brown & R. Lent (Eds.), *Handbook of counseling psychology* (pp. 785-831). New York: John Wiley.

Center for Disease Control and Prevention. (2002). Youth risk behavior surveillance, United States, 2001. *Mortality and Morbidity Weekly Review, 51.* Atlanta, GA: Center for Disease Control and Prevention.

Center for Disease Control and Prevention. (2006). Youth Risk Behavior Surveillance, United States, 2005. *Morbidity and Mortality Weekly Report, 55.* Atlanta, GA: Center for Disease Control and Prevention.

Cervantes, J.M., & Ramírez, O. (1992). Spirituality and family dynamics in psychotherapy with Latino children. In L.A. Vargas & J.D. Koss-Chioino (Eds.), *Working with culture: Psychotherapeutic interventions with ethnic minority children and adolescents* (pp. 103- 128). San Francisco, CA: Jossey-Bass.

Chavez, L.R. (1984). Doctors, curanderos, and brujas: Health care delivery and Mexican immigrants in San Diego. *Medical Anthropology Quarterly, 15,* 636-645.

Cicchetti, D., & Cohen, D.J. (1995). *Developmental psychopathology.* New York: John Wiley.

Cuellar, I., Siles, R.I., & Bracamontes, E. (2004). Acculturation: A psychological construct of continuing relevance for Chicana/o psychology. In R.J. Velasquez, L.M. Arellano, & B.W. McNeill (Eds.), *The handbook of Chicana/o psychology and mental health,* (pp. 23-42). Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Doi, Y., Roberts, R.E., Takeuchi, K., & Suzuki, S. (2001). Multiethnic comparison of adolescent major depression based on the DSM-IV criteria in a U.S.-Japan study. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*, 1308-1315.

Downey, G., & Coyne, J.C. (1990). Children of depressed parents: An integrative review. *Psychological Bulletin, 108,* 50-76.

Echeverry, J.J. (1997). Treatment barriers accessing and accepting professional help. In J.G. García, and M.C. Zea (Eds.), *Psychological interventions and research with Latino populations* (pp. 94-107). Boston, MA: Allyn and Bacon.

Edgerton, R.B., & Karno, M. (1971). Mexican-American bilingualism and the perception of mental illness. *Archives of General Psychiatry, 24*, 286-290.

Erlandson, D.A., Harris, E.L., Skipper, B.L., & Allen, S.D. (1993). *Doing naturalistic inquiry: A guide to methods.* Newbury Park, CA: Sage.

Falicov, C.J. (1996). Mexican families. In M. McGoldrick, J. Giordano & J.K. Pearce (Eds.), *Ethnicity and family therapy* (2nd ed., pp. 169-182). New York, NY: Guildford Press

Famularo, R., Kinscherff, R., & Fenton, T. (1992). Psychiatric diagnoses of maltreated children: Preliminary findings. *Journal of the American Academy of Child and Adolescent Psychiatry, 31,* 863-867.

Felkenes, G.T., & Becker, H.K. (1995). Female gang members: A growing issue for policy makers. *Journal of Gang Research, 2*, 1-10.

Flaskerud, J.H. (1986). The effects of culture-compatible intervention on the utilization of mental health services by minority clients. *Community Mental Health Journal, 22,* 127-141.

Fontana, A., & Frey, J.H. (1994). Interviewing: The art of the science. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 361-376). Thousand Oaks, CA: Sage.

Franklin, C., & Corcoran, J. (2000). Preventing adolescent pregnancy: A review of programs and practices. *Social Work, 45*, 40-52.

Friedman, R., Katz-Leavy, J., Manderscheid, R., & Sondhemer, D. (1996). Prevalence of serious emotional disturbance in children and adolescents. In R.W. Manderscheid & M.A. Sonnenschein (Eds.), *Mental health, United States* (pp.77-91). Washington, DC: U.S. Government Printing Office.

Gilbert, M.J. (1980). *Mexican-Americans parents' perceptions of folk childhood diseases: Little evidence of a strong folk tradition.* Paper presented at the Annual Meeting of the American Anthropological Association, Los Angeles, CA.

Gittelman, R., Mannuzza, S., Shenker, R., & Bonagura, N. (1985). Hyperactive boys almost grown up. I. Psychiatric status. *Archives of General Psychiatry, 42,* 937-947.

Gittelman-Klein, R. (1978). Validity of projective tests for psychodiagnosis in children. In R.L. Spitzer & D.F. Klein (Eds.), *Critical issues in psychiatric diagnosis* (pp. 141-165). New York: Raven Press.

Glaser, B.G. (1978). *Theoretical sensitivity.* Mill Valley, CA: The Sociology Press.

Goldstein, A.P., & Soriano, F.I. (1994). Juvenile gangs. In L.D. Eron (Ed.), *Reason to hope: A psychosocial perspective on violence & youth* (pp. 315-333). Washington, DC: American Psychological Association.

González, G.M. (1997). The emergence of Chicanos in the twenty-first century: Implications for counseling, research, and policy. *Journal of Multicultural Counseling and Development, 25,* 94-106.

Goodman, S.H., Sewell, D.R., & Jampol, R.C. (1984). On going to the counselor: Contributions of life stress and social supports to the decision to seek psychological counseling. *Journal of Counseling Psychology, 31*, 306-313.

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Research Information Center Annual Review Paper, 29*, 75-91.

Guba, E.G., & Lincoln, Y.S. (1994). Competing paradigms in qualitative research. In N.K. Denzin (Ed.), *Handbook of qualitative research* (pp. 105-117). Thousand Oaks, CA: Sage.

Guendelman, S., & Schwalbe, J. (1986). Medical care utilization by Hispanic children: How does it differ from black and white peers? *Medical Care, 24,* 925-940.

Guzmán, B. (2001). *The Hispanic population: Census 2000 brief*. U.S. Census Bureau: Washington, DC.

Hall, L.E. (2005). *Dictionary of Multicultural Psychology: Terms, Issues, and Concepts.* Thousand Oaks, CA: Sage Publications.

Harris, M.G. (1994). Cholas: Mexican American girls and gangs. *Sex Roles, 30*, 289-301.

Harris, M.L. (1998). *Curanderismo and the DSM-IV: Diagnostic and treatment implications for the Mexican American client* (Tech. Rep. No. 45). East Lansing, MI: Michigan State University.

Harris, M., Velásquez, R.J., White, J., & Renteria, T. (2004). Folk healing and curanderismo within the contemporary Chicana/o community: Current status. In R.J. Velásquez, L.M. Arellano & B.W. McNeill (Eds.), *The handbook of Chicana/o psychology and mental health*, 111-125. Mahawah, NJ: Lawrence Erlbaum Associates.

Hathaway, S.R., & McKinley, J.C. (1989). Minnesota Multiphasic Personality Inventory-II. Minneapolis, MN: University of Minnesota.

Helzer, J.E., Burnham, M.W., & McEvoy, L.T. (1991). Alcohol abuse and dependence. In L.N. Robins, & D.A. Regier (Eds.), *Psychiatric disorders in America* (pp. 81-116). New York: Free Press.

Hoberman, H.M. (1992). Ethnic and minority status and adolescent mental health services utilization. *Journal of Mental Health Administration, 19*, 246-267.

Hymes, R.W., & Akiyama, M.M. (1991). Depression and self-enhancement among Japanese and American students. *Journal of Social Psychology, 13,* 321-334.

Instituto Nacional Indigenista/Secretaria de Salubridad y Asistencia. (1993). *Salud de los pueblos indigenas.* Mexico D.F., Mexico: Author.

Iwamasa, G.Y., & Pai, S.M. (2003). Anxiety disorders among ethnic minority groups. In G. Bernal, J.E. Trimble, A.K. Burlew, & F.T.L. Leong (Eds), *Handbook of racial and ethnic minority psychology* (pp. 429-447). Thousand Oaks, CA: Sage Publications.

Jaco, E.G. (1959). *Mental health of the Spanish American in Texas, culture and mental health: Cross culture studies.* New York: Macmillan.

Jacob, E. (1987). Qualitative research traditions: A review. *Educational Research 57, 1-50.*

Jensen, P.S. (1998). Developmental psycho-pathology courts developmental neurobiology: Current issues and future challenges. *Seminars in Clinical Neuropsychiatry, 3,* 333-337.

Jones, E.E., & Korchin, S.J. (1982). Minority mental health: Perspectives. In E.E. Jones, & S.J. Korchin (Eds.), *Minority Mental Health* (pp. 3-36). New York: Praeger.

Karno, M., Golding, J.M., Sorenson, S.B., & Burnham, M.A. (1988). The epidemiology of obsessive-compulsive disorder in five U.S. communities. *Archives of General Psychiatry, 45,* 1094-1099.

Karno, M., Hough, R.L., Burnham, A., Escobar, J.I., Timbers, D.M., Santana, F., & Boyd, J.H. (1987). Lifetime prevalence of specific psychiatric disorders among Mexican Americans and non-Hispanic Whites in Los Angeles. *Archives of General Psychiatry, 44,* 695-701.

Kaufman, J. (1991). Depressive disorders in maltreated children. *Journal of the American Academy of Child and Adolescent Psychiatry, 30,* 257-265.

Kay, M. (1977). Health and illness in a Mexican-American barrio. In E.H. Spicer (Ed.), *Ethnic medicine in the southwest* (pp. 99-166). Tucson, AZ: University of Arizona Press.

Kazdin, A.E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology, 65*, 453-463.

Kazdin, A.E., Moser, J., Colbus, D., & Bell, R. (1985). Depressive symptoms among physically abused and psychiatrically disturbed children. *Journal of Abnormal Psychology, 94,* 298-307.

Keefe, S.M. (1981). Folk medicine among urban Mexican-Americans: Cultural persistence, change and displacement. *Hispanic Journal of Behavioral Sciences, 3,* 41-58.

Keefe, S.M., Padilla, A.M., & Carlos, M.L. (1978). *Emotional support system in two cultures: A comparison of Mexican Americans and Anglo Americans* (Occasional Paper No. 7). Los Angeles: University of California, Spanish Speaking Mental Health Research Center.

Kimberling, R., & Baumrind, N. (2005). Access to Specialty Mental Health Services Among Women in California. *Psychiatric Services, 56*, 729-734.

Koss-Chioino, J.D. (2000). Traditional and folk approaches among ethnic minorities. In J.F. Aponte & J. Wohl (Eds.), *Psychological Intervention and Cultural Diversity* (pp. 149-166). Boston, MA: Allyn and Bacon.

Kovacs, M. (1985). The children's depression inventory. *Psychopharmacology Bulletin, 21*, 995-998.

Kovacs, M., Devlin, B., Pollock, M., Richards, C., & Mukerji, P. (1997). A controlled family history study of childhood-onset depressive disorder. *Archives of General Psychiatry, 54*, 613- 623.

Lavigne, J.V., Gibbons, R.D., Christoffel, K.K., Arend, R., Rosenbaum, D., Binns, H., Dawson, N., Sobel, H., & Isaacs, C. (1996). Prevalence rates and correlates of psychiatric disorders among preschool children. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 204-214.

Leaf, P.J., Alegria, M, Cohen, P., Goodman, S.H., Horwitz, S.M., Hoven, C.W., Narrow, W.E., Vaden-Kiernan, M., & Regier, D.A. (1996). Mental health service use in the community and schools: Results from the four-community MECA Study. Methods for the epidemiology of child and adolescent mental disorders study. *Journal of the American Academy of Child and Adolescent Psychiatry, 35,*889-897.

Leckman, J.F., Peterson, B.S., Pauls, D.L., & Cohen, D.J. (1997). Tic disorders. *Psychiatric Clinics of North America, 20*, 839-861.

Lee, G. (1947). *Our Lady of Guadalupe: Patroness of the Americas.* New York: Catholic Book.

Leonard, H.L., Rapoport, J.L., & Swedo, S.E. (1997). Obsessive-compulsive disorder. In J.M. Weiner (Ed.), *Textbook of child and adolescent psychiatry* (2nd ed., pp. 481-490). Washington, DC: American Academy of Child and Adolescent Psychiatry, American Psychiatric Press.

Leong, F.T.L., Wagner, N.S., & Tata, S.P. (1995). Racial and ethnic variations in help-seeking attitudes. In J.G. Ponterotto, J.M Casas, L.A. Suzuki, & C.M. Alexandra (Eds.), *Handbook of Multicultural Counseling* (pp. 415-438). Thousand Oaks, CA: Sage Publications.

Leslie, L.A., & Leitch, M.L. (1989). A demographic profile of recent Central American immigrants: clinical and service implications. *Hispanic Journal of Behavioral Sciences, 1*, 315-329.

Levine, E., & Padilla, A. (1980). *Crossing cultures in therapy: Pluralistic counseling for the Hispanic.* Monterey, CA: Brooks/Cole.

Lyon, J.M., Henggeler, S.W., & Hall, J.A. (1992). The family relations, peer relations, and criminal activities of Caucasian and Hispanic-American gang members. *Journal of Abnormal Child Psychology, 20*, 439-449.

Malgady, R.G., Rogler, L.H., & Constantino, G. (1988). Ethnocultural and linguistic bias in mental health evaluation of Hispanics. *American Psychologist, 42,* 228-234.

Manderscheid, R.W., & Barrett, S.A. (Eds.) (1987). *Mental health in the United States* (DHHS Publication No. ADM 87-1518). Washington, DC: U.S. Government Printing Office.

Martin, J.A., Hamilton, B.E., Sutton, P.D., Ventura, S.J., Menacker, F., & Munson, M.L. (2005). Births: final data for 2003. *National Vital Statistics Reports, 54*.

McCabe, K.M. (2002). Factors that predict premature termination among Mexican-American children in outpatient psychotherapy. *Journal of Child and Family Studies, 11*, 347-359.

McCabe, K., Yeh, M., Hough, R., Landsverk, J., Hurlburt, M., Culver, S., & Reynolds, B. (1999). Racial/ethnic representations across five public sectors of care for youth. *Journal of Emotional and Behavioral Disorders, 7,* 72-82.

McNeill, B.W., Prieto, L.R., Flores Niemann, Y., Pizarro, M., Vera, E.M., & Gomez, S.P. (2001). Current directions in Chicana/o psychology. *The Counseling Psychologist, 29*, 5-17.

Mio, J.S., Barker-Hackett, L., & Tumambing, J. (2006). *Multicultural Psychology: Understanding Our Diverse Communities.* Boston, MA: McGraw-Hill.

Miranda, J., Lawson, W., & Escobar, J. (2002). Ethnic minorities. *Mental Health Services Research, 4,* 231-237.

Muñoz, R.A., Boddy, P., Prime, R., & Muñoz, L. (1990). Depression in the Hispanic community: Preliminary findings in Hispanic general medical patients at a community health center. *Annals of Clinical Psychiatry, 2*, 115-120.

National Institute of Mental Health. (1998). *Genetics and mental disorders: Report of the National Institute of Mental Health's genetics workgroup.* (NIH Publication NO. 98-4268). Rockville, MD: NIMH.

Neff, J.A., & Hoppe, S.K. (1993). Race/ethnicity, acculturation, and psychological distress: Fatalism and religiosity as cultural resources. *Journal of Community Psychology, 21*, 3-20.

O'Brien, E.M. (1993). Latinos in higher education. *Research Briefs, 4*, 1-15.

Organista, K.C. (2003). Mexican American children and adolescents. In J.T. Gibbs & L.N. Huang (Eds.), *Children of Color* (pp. 344-381). San Francisco, CA: John Wiley & Sons.

Padgett, D.K., Patrick, C., Burns, B.J., & Schlesinger, H.J. (1994). Ethnic differences in use of inpatient mental health services by Blacks, Whites, and Hispanics in a national insured population. *Health Services Research, 29,* 135-153.

Padgett, D.K., Patrick, C., Burns, B.J., & Schlesinger, H.J. (1994b). Ethnicity and the use of outpatient mental health services in a national insured population. *American Journal of Public Health, 84,* 222-226.

Padilla, A.M. (Ed.). (1980). *Acculturation: Theory, models, and some new findings.* Boulder, CO: Westview Press.

Padilla, A.M., Carlos, M.L., & Keefe, S.E. (1976). Mental health service utilization by Mexican Americans. In M.R. Miranda (Ed.), *Psychotherapy with the Spanish-Speaking: Issues in research and service delivery* (monograph no. 3). University of California, Los Angeles: Spanish Speaking Mental Health Clinic.

Patterson, G.R. (1982). *Coercive family process.* Eugene, OR: Castalia.

Pine, D.S. (1997). Childhood anxiety disorders. *Current Opinion in Pediatrics, 9*, 329-338.

Poe-Yamagata, E., & Jones, M.A. (2000). *And Justice for Some: Differential Treatment of Minority Youth.* Washington, DC: Youth Law Center.

Prieto, L.R., McNeill, B.W., Walls, R.G., & Gomez, S.P. (2001). Chicanas/os and mental health services: An overview of utilization, counselor preference, and assessment issues. *The Counseling Psychologist, 29*, 18-54.

Ramírez, O. (1998). Mexican American children and adolescents. In J.T. Gibbs and L.N. Huang (Eds.), *Children of color: Psychological interventions with culturally diverse youth* (pp. 215-239). San Francisco, CA: Jossey-Bass.

Reynolds, W.M. (1986). *Reynolds adolescent depression scale.* Odessa, TX: Psychological Assessment Resources.

Rivera, G., Jr. (1988). Hispanic folk medicine utilization in urban Colorado. *Sociology and Social Research, 72*(4), 237-241.

Rivera, G., Jr., & Wanderer, J.J. (1986). Curandersimo and childhood illnesses. *The Social Science Journal, 23*, 361-372.

Roberts, R.E. (1994). An exploration of depression among Mexican origin and Anglo adolescents. In R. Malgady, & O. Rodriguez (Eds.), *Theoretical and Conceptual Issues in Hispanic Mental Health Research* (pp. 92-112). Malabar, FL: Kreiger Publishing.

Roberts, R.E., Roberts, C.R. & Chen, Y.R. (1997). Ethnocultural differences in prevalence of adolescent depression. *American Journal of Community Psychology, 25*, 95-110.

Rochín, R. I., & de la Torre, A. (1996). Chicanas/os in the economy since 1970. In E.R. Maciel & I.D. Ortiz (Eds.). *Chicanas/Chicanos at the Crossroads* (pp. 52-80). Tucson, AZ: The University of Arizona Press.

Rodriguez, J. (1994). *Our Lady of Guadalupe: Faith and empowerment among Mexican American women.* Austin: University of Texas Press.

Rodriguez, N., Ramírez, M., & Korman, M. (1999). The transmission of family values across generations of Mexican, Mexican American, and Anglo-American families: Implications for mental health. In R.H. Sheets, & E.R. Hollins (Eds.), *Racial and ethnic identity in school practices: Aspects of human development* (pp. 141- 155). Mahwah, NJ: Erlbaum.

Rumberger, R.W. (1998). Achievement for Latinos through academic success. In P. Gandara, K. Larson, R. Rumberger, and H. Mehan (Eds.), *Capturing Latino Students in the Academic Pipeline.* Berkeley, CA: California Policy Seminar.

Rumberger, R.W., & Larson, K.A. (1994). Keeping high risk Chicano students in school. In R.J. Rossi (Ed.), *Schools and Students at Risk,* (pp. 141-162). Berkeley, CA: Teacher's College Press.

Rutter, M., Silberg, J., O'Connor, T., & Simonoff, E. (1999). Genetics and child psychiatry: I. Advances in quantitative and molecular genetics. *Journal of Child Psychology and Psychiatry, 16*, 3-18.

Silva de Crane, R., & Spielberger, C.D. (1981). Attitudes of Hispanic, Black, and Caucasian university students toward mental illness. *Hispanic Journal of Behavioral Sciences, 9,* 241-255.

Simmons, R.C., & Hughes, C.C. (1993). Culture-bound syndromes. In A.C. Gaw (Ed.), *Culture, Ethnicity and Mental Illness* (pp. 75-99). Washington, DC: American Psychiatric Press.

Sleath, B.L., & Williams, J.W. (2004). Hispanic ethnicity, language, and depression: Physician-patient communication and patient use of alternative treatments. *International Journal of Psychiatry in Medicine, 34*, 235-246.

Smart, J.F., & Smart, D.W. (1991). Acceptance of disability and the Mexican American culture. *Rehabilitation Counseling Bulletin, 34*, 357-367.

Smetana, J.G., & Kelly, M. (1989). Social cognition in maltreated children. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: Theory and research on causes and consequences of child abuse and neglect* (pp. 620-646). New York: Cambridge University Press.

Snowden, L.R. (1999). African American folk idiom and mental health service use. *Cultural Diversity and Ethnic Minority Psychology, 5,* 364-370.

Solberg, V.S., Valdez, J., & Villarreal, P. (1994). Social support, stress, and Hispanic college adjustment: Test of a diathesis-stress model. *Hispanic Journal of Behavioral Sciences, 16,* 230-239.

Solorzano, D.G., & Solorzano, R.W. (1995). The Chicano education experience: A framework for effective schools in Chicano communities. *Educational Policy, 9*, 293-314.

Sroufe, L.A., & Rutter, M. (1984). The domain of developmental psychopathology. *Child Development, 55,* 17-29.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory (2nd ed.)*. Newbury Park, CA: Sage.

Sue, S., Fujino, D.C., Hu, L.T., Takeuchi, D.T., & Zane, N.W. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 59*, 533-540.

Sue, S., Zane, N., & Young, K. (1994). Research on psychotherapy with culturally diverse populations. In A. Bergin & S. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 783-817). New York: John Wiley.

Temkins-Greener, H., & Clark, K.T. (1988). Ethnicity, gender, and utilization of mental health services in a Medicaid population. *Social Science & Medicine, 26*, 989-996.

Thomas, C.R., & Holzer, C.E., III. (1999). National distribution of child and adolescent psychiatrists. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*, 9-15.

Treviño, F.M., & Moss, A.J. (1984). Health indicators for Hispanic, Black and White Americans. *Vital and Health Statistics, 10(148)*. Washington, DC: Government Printing Office.

U.S. Census Bureau. https://ask.census.gov/cgi-bin/askcensus.cfg/php/enduser/std_adp.php?p_faqid=315&p_created=1078334778&p_sid=Hs2hsVgi&p_lva=&p_sp=cF9zcmNoPTEmcF9zb3J0X2J5PSZwX2dyaWRzb3J0PSZwX3Jvd19jbnQ9NDMmcF9wcm9kcz0mcF9jYXRzPSZwX3B2PSZwX2N2PSZwX3BhZ2U9MSZwX3NlYXJjaF90ZXh0PWhpc3Bhbmlj&p_li=&p_topview=1

U.S. Office of Technology Assessment. (1986). *Children's mental health: Problems and service- a background paper.* Washington, DC: U.S. Government Printing Office.

Valencia, R.R. (Ed.). (1991). *Chicano School Failure and Success: Research and Policy Agendas for the 1990s.* New York: Falmer Press.

Valencia, R.R. (Ed.). (2002). *Chicano School Failure and Success: Past, Present, and Future.* New York: RoutledgeFalmer.

Vega, W.A., Kolody, B., Aguilar-Gaxiola, S., Alderete, E., Catalano, R., & Caraveo-Anduaga, J. (1998). Lifetime prevalence of DSM-III psychiatric disorders among urban and rural Mexican Americans in California. *Archives of General Psychiatry, 55,* 771-778.

Vigil, J.D. (1999). Streets and schools: How educators can help Chicano marginalized gang youth. *Harvard Educational Review, 69*, 270-288.

Watson, S. (1964). *The Cult of Our Lady of Guadalupe.* Collegeville, MN: Liturgical Press.

Weinberg, W.A., & Emslie, G.J. (1987). Depression and suicide in adolescents. *International Pediatrics, 2*, 154-159.

Weissman, M.M., Warner, V., Wickramaratne, P., Moreau, D., & Olfson, M. (1997). Offspring of depressed parents. 10 years later. *Archives of General Psychiatry, 54,* 932-940.

Wickramaratne, P., & Weissman, M.M. (1998). Onset of psychopathology in offsprings by developmental phase and parental depression. *Journal of the American Academy of Child and Adolescent Psychiatry, 37,* 933-942.

Wells, K.B., Hough, R.L., Golding, J.M., Burnam, M.A., & Karno, M. (1987). Which Mexican Americans underutilize health services? *American Journal of Psychiatry, 144*, 918-922.

Woodward, A.M., Dwinell, A.D., & Arons, B.S. (1992). Barriers to mental health care for Hispanic Americans: A literature review and discussion. *Journal of Mental Health Administration, 19,* 224-236.

Yeh, M., McCabe, K., Hough, R.L., Lau, A., Fakhry, F., & Garland, A. (2005). Why bother with beliefs? Examining relationships between race/ethnicity, parental beliefs about causes of child problems, and mental health service use. *Journal of Consulting and Clinical Psychology, 73*, 800-807.

Zea, M.C., Jarama, S.L., & Trotta Bianchi, F. (1995). Social support and psychosocial competence: Explaining the adaptation to college of ethnically diverse students. *American Journal of Community Psychology, 23,* 509-531.

Zhang, A.Y., & Snowden, L.R. (1999). Ethnic characteristics of mental disorders in five U.S. communities. *Cultural Diversity and Ethnic Minority Psychology, 5,* 134-146.

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